



ALTERNATE ROUTES OF REFORMIST ACTIVISM: MEDICAL MARIJUANA AS A CASE STUDY OF INITIATIVES WITHIN AND BEYOND STATUTORILY PRESCRIBED CHANNELS

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**ALTERNATE ROUTES OF REFORMIST ACTIVISM:
MEDICAL MARIJUANA AS A CASE STUDY OF INITIATIVES
WITHIN AND BEYOND STATUTORILY PRESCRIBED
CHANNELS**

Submitted to Professor Peter Barton Hutt in Satisfaction
of the Written Work Requirement.

Linda LeCraw
April 12, 1996

Content S

Introduction	1
Part One: The Controlled Substances Act	3
Part Two: History of Administrative and Court Action under the Controlled Substances Act	8
Part Three: Beyond Statutorily Prescribed Channels: Alternative Avenues to Reform	50
<i>Medical Marijuana Access through the Federal Investigational New Drug Program</i>	52
<i>State Common Law: Reception off the Medical Necessity Defense</i>	58
<i>State Statutory and Electoral Initiatives</i>	82
Conclusion	95

**ALTERNATE ROUTES OF REFORMIST ACTIVISM:
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Introduction:

As news reports detail the growing problems of crack cocaine and heroin abuse in the inner city, marijuana seems to have drifted from the spotlight of public alarm. According to a recent article in the Atlantic Monthly, however, this impression is deceptive, as marijuana use remains a major and growing concern for law enforcement officials nationwide. The article contends that today there may be more people in federal and state prisons for marijuana offenses than at any other time in U.S. history.¹ But despite the laws prohibiting marijuana, many remain ardent supporters of the substance, claiming that it will one day be hailed as a safe and inexpensive miracle drug.² These supporters maintain, as medical marijuana expert Dr. Lester Grinspoon of Harvard Medical School has stated, that opposition to the drug's medical use stems from the largely irrational fears of many people in government f who] see marijuana as a catalyst to authority questioning... because of its association with the authority questioning movements of the 1960s. Grinspoon explains that these individuals are afraid marijuana would become freely available if

¹Eric Schiosser, "Reefer Madness," The Atlantic Monthly, Aug. 1994, at 45.

at 47.

permitted for medical purposes, and consequently they refuse to allow its use even under a doctor's supervision.³ However, opponents of medical marijuana use dismiss claims of the drug's medical effectiveness, and one spokesman for the opposition has retorted that the pro-legalization folks have been smoking too much of their own product.⁴

The struggle between those who support and those who oppose medical use of marijuana has been playing itself out for approximately a quarter-century, as private citizens and groups have undertaken repeated initiatives for government recognition of marijuana's medical effectiveness. These efforts began along the legislatively prescribed route of petitioning for agency action and appealing agency decisions in federal court. This approach spawned no changes, however, and thus proponents of medical marijuana use have pursued other avenues for reform, leading them to state courts, state legislatures, the halls of Congress, and elsewhere.

This essay discusses these various legal and political initiatives undertaken by reformers seeking change in the laws on medical marijuana use. Part I reviews the provisions of the Controlled Substances Act, and marijuana's status under the Act. Part II recounts the history of initiatives undertaken along the statutorily prescribed route for the Act's reform: citizens' petitions seeking administrative action, and court review of administrative decisions. Part

³Telephone interview with Dr. Lester Grinspoon, M.D., Associate Professor at Harvard Medical school (March 27, 1996).

⁴Telephone interview with Jesus Arredondo, Deputy Press Secretary for California Governor Pete Wilson (March 26, 1996).

III then surveys other fronts on which citizens and groups have attempted to make progress on the issue of medical marijuana, in the face of their fruitless efforts through the legislatively prescribed channels. While the outcomes of the current initiatives have not yet been determined, the conclusion addresses the significance of the controversy itself, as demonstration of the multiform power maintained by the people in our federalist democracy.

Part One:
The Controlled **Substances Act**

In 1970, Congress passed the Controlled Substances Act⁵ to address comprehensively the growing problem of illegal drug abuse. The Act establishes five schedules in which controlled substances are classified, ranging from schedule I (the strictest restrictions, recognizing no legitimate medical uses) to schedule V (the least restrictions). Schedule I is reserved for any drug or other substance (that] has a high potential for abuse, ... no currently accepted medical use in treatment in the United States, and for which there is a lack of accepted safety for use of the drug or other substance under medical supervision.⁶ Schedule II also applies to drugs and other substances with a high

⁵controlled Substances Act, 21 usc §§ 801-971 (1994).

⁶ § 812(b) (1).

potential for abuse, specifying that abuse of the drug or other substance (in schedule II] may lead to severe psychological or physical dependence.⁷ However, schedule II is limited to those substances which, despite their abuse potential, have a currently accepted medical use in treatment in the United States, or a currently accepted medical use with severe restrictions.⁸

The Act applies schedule III status to drugs that have a potential for abuse less than the drugs or other substances in schedules I and II, ... a currently accepted medical use in treatment in the United States, and for which abuse of the drug or other substance may lead to moderate or low physical dependence or high psychological dependence.⁹ Schedule IV requires that the drug or other substance so classified has a low potential for abuse relative to the drugs or other substances in schedule III, ... has a currently accepted medical use in treatment in the United States, and is of a nature that abuse of the drug or other substance may lead to limited physical dependence or psychological dependence relative to the drugs or other substances in schedule III.¹⁰ Finally, schedule V requires that a drug or other substance has a low potential for abuse relative to the drugs or other substances in schedule IV, ... has a currently accepted medical use in treatment in the United States, and that abuse of the drug or other substance may lead to

§ 812(b) (3).

§ 812(b) (4).

limited physical dependence or psychological dependence relative to the drugs or other substances in schedule IV.¹¹

Sections 811 and 812 of the Act make clear that the initial classification of drugs and other substances within these five schedules was subject to change. In its initial sorting of specific drugs into the five schedules, Section 812 states that Such schedules shall initially consist of the substances listed in this section,¹² and specifies that the initial classification of a drug in a particular schedule only applied unless and until amended pursuant to section 811 of this title.¹³ Section 811 vests in the Attorney General the authority to add drugs and other substances to a schedule and to transfer them between schedules, upon a finding that there is a potential for abuse and that the drug or other substance fits the criteria of the particular schedule. The Act also gives the Attorney General the power to remove drugs or other substances from the schedules altogether, upon a finding that the substances do not meet the requirements for inclusion in any schedule.

Proceedings for changing a substance's status may be undertaken at the initiation of the Attorney General or the Secretary of Health and Human Services¹⁴, or on the petition of any interested party.¹⁵ The Act provides that, following

~ § 812(b) (5).

12.I~ § 812(a).

¹³j~ § 812(c).

¹⁴In 1979, the Department of Health and Human Services became the successor in authority to the Department of Health, Education and Welfare. Department of Education Organization Act, Pub. L. 96-88, § 509, 93 Stat. 668, 695 (1979).

~21 usc § 811(a). secretary, as mentioned in 21 usc § 811(a), is

the initiation of such proceedings, the Attorney General should request from the Secretary a scientific and medical evaluation, and his recommendations, as to whether such drug or other substance should be so controlled or removed as a controlled substance. The Secretary's evaluation should address those of the Factors determinative of control or removal from schedules involving scientific or medical judgments: scientific evidence of its pharmacological effect, if known, the state of current scientific knowledge, potential risks to the public health, potential for psychological dependence, and whether the substance is an immediate precursor to a substance already controlled.⁶ The Act further declares that the Secretary's written recommendation about the appropriate scheduling of the substance shall be binding on the Attorney General as to such scientific and medical matters,¹⁷ which the Attorney General shall consider along with the substance's propensity for abuse.¹⁸

The Act specifically acknowledges the importance of controlled substances for medical use. It states that many of the drugs included.., have a useful and legitimate medical

defined in 21 usc § **802(24)** as the Secretary of Health and Human Services.
16~ § 811(c).

¹⁸j~. § 811(c)(1),(4), and (5). Section 811(b) instructs the Attorney General to defer to the Secretary's judgments on the medical and scientific criteria set forth in § 811(2), (3), (6), (7), and (8), and to any scientific or medical considerations relevant to the questions of abuse. However, the ultimate determination on this question of propensity for abuse, as set forth in § 811 (1), (4), and (5), is left to the Attorney General.

purpose and are necessary to maintain the health and general welfare of the American people,¹⁹ and recognizes legitimate medical uses for those substances in Schedules II, III, IV, and V. Within this framework, the Act's classification of marijuana (derived from the cannabis plant) as a Schedule I controlled substance has aroused marked controversy since the time of the Act's passage, because opinions differ on whether marijuana has legitimate medical applications.

The Act's legislative history reflects a wide divergence of opinion on the issue of marijuana classification among the drafters of the Act,²⁰ and consequently the Act established a Commission on Marijuana and Drug Abuse²¹ to study marijuana use and to make recommendations to the President and Congress about how it should be regulated. Congress' initial scheduling of marijuana as a Schedule I drug followed the recommendations of the Department of Health, Education and Welfare (HEW).²² As explained above, Congress delegated to HEW the authority to make determinations about the medical and scientific criteria for drug scheduling because HEW had an expertise in this area that the Attorney General lacked. Congress delegated any future modifications of scheduling to the Department of Justice (via the Attorney General), but made the initial classifications itself, and therein followed

¹⁹ 8 U.S.C. § 801(1).

²⁰ H.R. Rep. No. 91-1444, Interstate and Foreign commerce committee, 91st cong., 2d Sess. (sept. 10, 1970).

²¹ 21 U.S.C. § 801, Sec. 601.

²² In 1979, the Department of Health and Human Services replaced the Department of Health, Education, and Welfare as the authority on such scientific matters. See note 14.

HEW's recommendations in much the same way that it recommended the Attorney General follow them for future determinations.

HEW's recommendation, which Congress adopted in its initial scheduling of marijuana, was that marihuana be retained within schedule I at least until the completion of certain studies now underway²³. However, the Commission's findings never led to an alteration in the scheduling of marijuana, and private citizens favoring rescheduling soon invoked their power under the Act to initiate a review of the scheduling determination.

Part Two:
History of Administrative and Court Action
under the Controlled Substances Act

As mentioned previously, the Controlled Substances Act provides that any interested party may petition the Department of Justice for a change in the scheduling of a drug² This provision was first invoked in 1972, by the National Organization for the Reform of Marijuana Laws (NORML), a citizens group founded in 1970 in Washington D.C. by R. Keith Stroup, a concerned attorney³⁵

²³H.R. Rep. No. 91-1444, ~ note 20.

2421 usc § 811(a) (2) provides that such a change may be initiated by the Attorney General of the Department of Justice either at his request, the secretary's request, or on the petition of any interested party. NORML petitioned the BNDD because that was the bureau to which the Attorney General had delegated such matters.

²⁵Telephone interview with Allen St. Pierre, Deputy National Director of NORML (January 17, 1996).

In 1972, NORMI petitioned the branch of the DOJ designated for such issues, the Bureau of Narcotics and Dangerous Drugs (BNDD). Joined in its petition by the Institute for the Study of Health and Society and the American Public Health Association, NQRML requested either the elimination of restrictions on marijuana or its reclassification as a Schedule V controlled substance. Invoking 21 USC 811 (b) and (c)²⁶, the petitioners asserted that the question must be passed on to the Secretary of HEW, since it raised scientific and medical questions.

The BNDD disagreed, however, pointing to section 202(b), which exempts from such review drug controls that are required by United States obligations under an international treaty, convention, or protocol, in effect on the effective date of this part, and to section 201(d), which states that if control is required by United States obligations under international treaties, the authority vested in other agencies elsewhere in the Act does not apply and the Attorney General (whose authority was delegated to BNDD through the DOJ) shall issue an order controlling such drug under the schedule he deems most appropriate to carry out such obligations.²⁷ The BNDD concluded that the United States had such an international obligation regarding marijuana control, as a party to the Single Convention on

²⁶Note: 21 usc § 811 and 812 are equivalent to Pub. L. No. 91-513, title II, §§ 201 and 202. NORMI sometimes refers to them as §§ 201 and 202. However, for purposes of clarity, they will be cited as §§ 811 and 812 throughout this discussion.
²⁷21 usc § 811(d).

Narcotic Drugs, 1961, 18 U.S.T. 1407 (1967). On this basis, the Director of the BNDD, John Ingersoll, maintained that he held full authority to control marijuana in the schedule most appropriate to carry out international obligations of the United States. 28 However, Ingersoll offered no analysis of why the Single Convention on Narcotic Drugs required marijuana to be placed specifically in Schedule I of Act; he concluded only that the Single Convention required some sort of control over marijuana, without providing any justification for his choice of Schedule I.

In fact, the Single Convention clearly would have allowed the use of marijuana for medical purposes. The Convention's General Obligations stated that the parties must take measures necessary to limit exclusively to medical and scientific purposes the production, manufacture, export, import, distribution of, trade in, use and possession of drugs.²⁹ The Single Convention places marijuana in its most restrictive category, Schedule IV of the Convention, thereby restricting it to only medical and scientific uses, but clearly allowing those specific uses. Although the Convention suggests that nations may elect for stronger measures in exceptional circumstances where the threat to the public health and welfare is exceedingly great,³⁰ it clearly

2837 Fed. Reg. 18097 (1972)

²⁹Single convention on Narcotic Drugs, Mar. 30-Aug. 1, 1961, art.

4(1)(c), 18 U5T 1407, 1413.

³⁰Id at 1411. Article 2(5)(b) of the convention states that a nation may, in such circumstances, elect to prohibit the production, manufacture, export and import of, trade in, possession or use of any such drug except for amounts which may be necessary for medical and scientific research only.

does not require such action, as it condones medical use of substances under its Schedule IV.³¹ The Convention does place some additional restrictions specifically on marijuana, yet these too would allow medical use. These restrictions, invoked by Article 28: Control of Cannabis, make applicable to marijuana the system of controls as provided in article 23 respecting the control of opium poppy.³² That section provides for the establishment of national agencies to oversee the production and distribution of the drug, by designating areas for cultivation, licensing growers, and serving as a clearinghouse for crops.³³ However, the article underscores again the acceptability of medicinal use of the drug, stating that while the agency shall have the exclusive right of importing, exporting, wholesale trading and maintaining stocks, ... parties need not extend this exclusive right to medicinal opium and opium preparations.³⁴

Thus, because it permits medical uses of marijuana, the Single Convention would have allowed the United States to

31j~ at 1411. Article 2(1) and (5) of the convention indicate that

articles 4(c), 19, 20, 21, 29, 30, 31, 32, 33, 34, and 37 all apply to Schedule iV drugs. Medical use of a drug is consistent with all of these articles.

It is an interesting caveat that when amendments to the single convention were later proclaimed by u.s. President Gerald Ford, on August 29, 1975, Robert Ingersoll was the Acting secretary of State and as such he cosigned the proclamation. Like the original convention, these amendments did not prohibit medical use of marijuana, although they did provide that a party could elect to prohibit all cultivation if it found such a measure necessary. It is unclear whether this underscoring of article 39 of the original convention (which allowed nations to establish stricter measures domestically than the standards mandated by the convention) was triggered in part by the controversy surrounding marijuana's scheduling..I~.

32~ at 1421, art. 28(1).

~ at 1419, art. 23. at 1419, art. 23(2)(e).

place marijuana in a category less restrictive than Schedule

I. Ingersoll did not, however, address this, as his rejection of NORML's petition asserted only his general authority to make scheduling determinations where international obligations were involved, and did not discuss why he chose to make the determination that he did. Consequently, Ingersoll's response also avoided addressing any of the petition's substantive arguments for rescheduling marijuana ~

NORML responded by bringing a law suit against Ingersoll, as prescribed by section 877 of the Act. Under section 877, any person aggrieved by a final decision of the Attorney General may obtain review of the decision in the United States Court of Appeals for the District of Columbia or for the circuit in which his principal place of business is located. Setting forth the standard of review (typical for review of agency decisions), section 877 states that findings of fact by the Attorney General [or his delegates], if supported by substantial evidence, shall be conclusive. 36

NORML alleged that Ingersoll had abused his power in rejecting the petition outright and refusing even to file it for further governmental consideration. The court agreed that Ingersoll had been overly hasty, and ordered a remand for further proceedings by the Drug Enforcement Agency (DEA), the agency of the DOJ that had recently taken over the

3537 Fed. Reg. 18097, ~ note 28.

3621 usc § 877.

functions delegated to the Attorney General in the Controlled Substances Act (which had previously been performed by the BNDD).

The court based its opinion on several strands of argument. Although NORML had not limited the focus of its original petition to the leaves of the cannabis plant, NORML argued to the court that the Convention only applies to cannabis and cannabis resin, which are clearly defined so as to be inapplicable to the plant's leaves. While the government acknowledged this, it urged the court to affirm Ingersoll's order nonetheless, with permission to NORML to file another petition limited to the leaves. The court, however, did not accept this procedural approach, as it claimed that

It is not at all unusual for persons seeking governmental action— from any of the branches— to pray for the maximum desired, or such other relief as may be deemed appropriate. To say that this may act as a disqualification from obtaining more limited relief is to strain ordinary conceptions of fair procedure, in the absence of an express warning or alert.³⁷

In adopting this greater-includes-the-lesser approach to rulemaking petitions, the court enabled NORML to bypass the additional procedural hurdle of filing another petition in order to have the issue of marijuana leaves addressed.

The court also rejected Ingersoll's contention that the mere presence of an international obligation involving the substance gave him blanket authority over its scheduling. On this issue, the court expressed concern that respondent's

v. Ingersoll, 497 F. 654, 659 (1974)

own unorthodox procedural devices may have contributed to a procedural impasse and a non-responsive discussion on different planes of discourse.³⁸ The court asserted that an outright rejection of a petition is a 'peremptory' action, soundly used only in 'the clear case of a filing that patently is either deficient in form or a substantive nullity. '~~ This case did not fit either of these categories, the court concluded, and thus such outright rejection was inappropriate. Rather, Ingersoll owed petitioners a determination on the merits of their request, in order to foster the interchange [between petitioner and agency] and refinement of views that the court called the lifeblood of a sound administrative process.

In remanding the case to respondent for consideration on the merits, the court placed important restrictions on Ingersoll. The court stated that the Act's special provisions for international obligations extended no further than necessary to meet international agreements. The court observed that the respondent seems to be saying that even though the treaty does not require more control than schedule V provides, he can on his own say-so and without any reason insist on Schedule I, ~ and the court rejected this contention, as it perceived such blanket unilateral authority to be contrary to Congressional intent. Even regarding the determination of what schedule was required by the Single

38~

~ citing Municipal Light Boards v. FPc, 146 U.5.App. D.C. 294, 298 (1971), cert. denied, 405 U.s. 989 (1972).

~¹⁰NoRML v Ingersoll, 497 F. 2d at 660-661.

41~ at 661.

Convention, the court stated that respondent's opinion should not govern exclusively, and that the views of sources in the State Department and the international organizations involved should be solicited. However, the court declined to rule on what course would be required if it were determined that international obligations allowed the United States latitude in marijuana scheduling depending on its assessment of the domestic health situation. Specifically, the court left open the question of whether the Department of Justice (through the DEA) would be required to seek the appraisal of HEW in making such health-related determinations, or whether it could make such determinations unilaterally ~41

Pursuant to this remand, the DEA undertook a rulemaking proceeding in accordance with the Administrative Procedure Act (APA), 5 USC 553 and 554, by publishing notice in the Federal Register that DEA was prepared to hold a hearing for the petitioners on the issues remanded by the court. Petitioners responded to this notice by requesting an administrative hearing, and the matter was brought before an administrative law judge. Although this procedure made public the administrative law judge's recommendations on the merits of NORML's petition, it gave the Acting Administrator of the DEA the ultimate authority to accept or reject that recommendation. In his recommended decision, Administrative Law Judge Lewis F. Parker concluded that the United States

had no international obligation to control cannabis seeds or artificial cannabis, and suggested that the DEA Administrator request an assessment by the Secretary of HEW regarding their rescheduling or removal from the list of controlled substances.⁴² Although Judge Parker determined that the United States is required by the treaty to control cannabis, cannabis resin, and cannabis leaves, he concluded that the nation's obligations thereunder can be satisfied if cannabis and cannabis resin are placed in Schedule II of the Controlled Substances Act and if cannabis leaves are placed in Schedule V of the Act. For this reason, Judge Parker suggested that the DEA Administrator request a scientific and medical evaluation by the Secretary of HEW on these issues as well ~

In his response to Judge Parker's recommended decision, DEA Administrator Henry S. Dogin agreed that artificial cannabis was not governed by any international agreement, and concluded that it was therefore not an issue in this proceeding. However, Dogin dismissed Judge Parker's conclusion that cannabis leaves could be placed in Schedule V. as Dogin found the differentiation to be appropriate only in the framework of an academic discussion, since marijuana in the illicit traffic is a mixture of crushed leaves, flowers, and twigs. He concluded therefore that the

⁴²In the Matter of National Organization for the Reform of Marijuana Laws. et al., unpublished opinion, u.s. Department of Justice, Drug Enforcement Agency, Administrative Law Judge Lewis F. Parker, May 21, 1975, Docket No. 74-7, 34. at 35.
~40 Fed. Reg. 44164 (1975)

over-the-counter availability carried by Schedule V classification could easily foster misuse that would violate international obligations. Dogin also rejected Judge Parker's contention that cannabis seeds need not be controlled under international obligations, as Dogin asserted that the seeds can be used to grow more plants, and thus they must be controlled if the Single Convention's obligations on the plant itself are to be met.⁴⁵

Dogin did not accept Judge Parker's suggestion that the Secretary of HEW be consulted regarding a possible rescheduling of the rest of the marijuana plant to Schedule II, a classification which Parker had found consistent with international obligations. Dogin admitted that Schedule II would satisfy the requirements of the Single Convention, as he agree[d] that the control mechanisms of the Act relating to Schedule I or Schedule II are sufficient to meet the requirements of the Single Convention as to cannabis and cannabis resin.⁴⁶ However, as discussed above, the D.C. Circuit had left open the question of whether the DEA Administrator should seek the HEW Secretary's advice on such a rescheduling issue, and Dogin asserted that he was not required to do so. He stated that the court did not repeal Section 201(d) of the Controlled Substances Act, and he invoked that provision to show that the solution, as Congress resolved it, was to place in the Attorney General [and his delegatee, the DEA Administrator] the ability to

at 44167.

46~

resolve mixed questions of law and science and medicine,⁴⁷ such as those presented by marijuana scheduling.

Thus Dogin made the scheduling determination without seeking HEW's advice specifically on rescheduling, although he did base his conclusion in part on the HEW Secretary's position on medical marijuana use, as will be discussed below. Dogin emphasized that although a Schedule II classification for marijuana would amply satisfy the Single Convention, any reclassification would need to be consistent with the Act itself, as Congress intended (and must have believed) that the Act and the treaty would be consistent.~ Because the Act set forth five schedules for controlled substances, the Administrator asserted that any classification must heed the guidelines of these schedules. He then pointed out that only Schedule I applied to substances having no accepted medical use in the United States, and he claimed that marijuana and the cannabis plant had no such accepted uses.

Dogin based this rejection of medical marijuana use in part on a letter to the DEA by Acting Secretary of HEW Dr. Theodore Cooper, which concluded that there is currently no accepted medical use of marihuana in the United States, and which was published in the same Federal Register notice as Dogin's decision. Based in part on this letter, Dogin concluded that marijuana had no accepted medical use, and that therefore placement of marihuana in Schedule I is less

48~ at 44168

discretionary than mandatory, due to the criteria set forth in the Act itself.⁴⁹ On this basis, he denied NORML's petition.⁵⁰

But the dispute was far from over. NORML again sought reconsideration by the court, and in 1977 the D.C. Circuit handed down its response.⁵¹ The court held that the DEA Administrator had overstepped his authority in assessing the appropriate classification for marijuana and cannabis under the Act itself. The Administrator's judgment was limited, the court asserted, to questions regarding international obligations. On determinations of compliance with the Act itself, the Administrator was required to share his decisionmaking function under the Act with the Secretary of HEW. ⁵² Merely referring to a letter by the Secretary without consulting him specifically on the rescheduling decision was not sufficient. The court reached this conclusion by analyzing both the text of the Act as well as its legislative history, and it read the latter of these to reflect intense concern with establishing and preserving HEW's avenue of input into scheduling decisions.⁵³ Thus, the court ruled that the Attorney General's discretion (delegated to the DEA Administrator) allowed him to disregard only those HEW recommendations that would lead to scheduling in violation of

⁵⁰Id

⁵¹NORML v. DEA, 559 F. 2d 735 (1977).

⁵²~ at 738.

at 746.

international commitments, not to exercise blanket authority over all drugs carrying any international obligations.⁵⁴

The court asserted that the proper allocation of decisionmaking responsibility between the Attorney General and the Secretary of HEW, in accordance with their respective spheres of expertise, enables the Attorney General (though the DEA) only to determine what minimum level of control is legally required by international obligations, in order to ensure that the Secretary's recommendation, which ordinarily would be binding as to medical and scientific findings, does not cause a substance to be scheduled in violation of treaty obligations.⁵⁵ Having determined that legal floor, however, the DEA must seek and heed the HEW Secretary's expert opinion on the other factors of the rescheduling determination. The court stated that:

Once that minimum schedule [required by international obligations] is established by the Attorney General [though the DEA], the decision whether to impose controls more restrictive than required by treaty implicates..., medical and scientific considerations. ... The Secretary of HEW is manifestly more competent to make these nonlegal evaluations and recommendations.⁵⁶

Moreover, the court asserted that an absence of accepted medical uses for a drug does not necessitate that the drug receive Schedule I classification.⁵⁷ This deflated the DEA's argument that the HEW Secretary's letter, which said only that marijuana had no currently accepted medical use, was

at 747.

56~

at 748.

dispositive of HEW's position on the rescheduling issue. The court determined that placement in Schedule I does not appear to flow inevitably from lack of a currently accepted medical use. The court interpreted the statute to reserve to HEW a finely tuned balancing process involving several medical and scientific considerations, such as potential for abuse and danger of dependence. The court thus found that medical use is but one factor to be considered, and by no means the most important one, and therefore concluded that by shortcutting the referral procedures [of the Act] ... the Acting Administrator precluded the balancing process contemplated by Congress.⁵⁸ On these grounds, the court remanded the petition back to DEA, directing the Administrator to refer it to the Secretary of HEW for the required medical and scientific findings and balancing assessments .

The court also discussed some of the controversy's more substantive issues. Addressing the requirements of the Single Convention on Narcotic Drugs, the court concluded, as the DEA Administrator had conceded, that the United States could reschedule cannabis and cannabis resin to Schedule II without violating the agreement. The court did not accept, however, the DEA Administrator's claim that marijuana leaves could not be in Schedule V without risking violation of the Single Convention. The court held that, because the treaty itself distinguished between the leaves and other parts of

58~

~ at 757.

the plant, such a rescheduling was permitted by the Convention, and thus the DEA Administrator was obliged to refer the petition to HEWA⁰ Although reviewing courts typically grant substantial deference to agency determinations, the court concluded here, We owe no deference to a statutorily invalid exercise of discretion.⁶¹

Similarly, the court found that the Administrator had abused his discretion in claiming that cannabis seeds must be controlled in order for international obligations to be met. Because the Single Convention did not specifically control marijuana seeds, the court concluded that The Acting Administrator's finding, like that regarding cannabis leaves, should have been deferred until after compliance with the referral and hearing requirements of Section 201(a)-(c).⁶²

The court even stepped beyond the issues raised by the petition itself, in evaluating the scheduling of synthetic THC⁶³, which was addressed at the hearing but not in the petition. The court asserted that synthetic THC was not regulated by any international obligation, and that NORML should be given a means to advocate its reclassification before the DEA even though it was not included in the original petition. On this basis, the court set forth specific guidelines for the mandated review by the Secretary of HEW, which instructed the Secretary to make separate

at 754.

61~

at 756.

⁶³THC is the principal psychoactive substance in cannabis. ~. at 756 n.88.

~NORML v. DEA, 559 F.2d at 756-757.

evaluations of synthetic THC, and of the three cannabis categories (cannabis resin, cannabis leaves, and cannabis seeds) within the confines of the treaty A⁵

The DEA Administrator complied with the court's mandate, and secured a detailed review from the Secretary of HEW, Joseph Califano. The Secretary based his assessment on a medical and scientific evaluation and recommendation by the Food and Drug Administration and the Alcohol, Drug Abuse and Mental Health AdministrationA⁶ This procedure, by which these Administrations review such issues for the Secretary, is required by 21 CFR Part 5, Subpart A, which delegates to the Commissioner of Food and Drugs, with authority to re-delegate except when specifically prohibited, the evaluative authority delegated to the Assistant Secretary for Health by the Secretary of HHS. Under 21 CFR 5.10(a) (9) and (10), this redelegation applies specifically to the Secretary's functions under the Controlled Substances Act. In his review, the Secretary explained that his position followed the evaluations of these reviewing Administrations, which had concluded that each of the listed cannabis materials should remain in Schedule I.~67 Consequently, the Secretary of HEW only fortified the DEA Administrator's position.

In reaching his conclusion, the Secretary set forth a thorough evaluation of the court-specified areas (cannabis

65~ at 757.

~44 Fed. Reg. 36123, 36125 (1979)

67~

68~ at 36123.

resin, cannabis leaves, cannabis seeds, and synthetic THC), evaluating them according to the scientific and medical criteria set forth in section 811 of the Act⁶⁹ Thus, the Secretary's review included a discussion of actual or relative potential for abuse, scientific evidence of its pharmacological effect, potential risk to public health, psychic or physiological dependence liability, and relation to other controlled substances.⁷⁰

However, in discussing his conclusion, which was that all the substances in question should remain in Schedule I, the Secretary addressed only the medical-use potential of marijuana, and did not adopt the balancing analysis of other factors that the court had prescribed on remand.⁷¹ The Secretary concluded that the substances we have reviewed could be placed in either Schedule I or Schedule II, and he based his Schedule I recommendation on medical-use evaluation, discussing none of the other factors set forth by the court or the Act. Specifically, the Secretary concluded that statutory language describing Schedule I substances as having no currently accepted medical use in treatment in the United States and a lack of accepted safety for use of the drug... under medical supervision fit marijuana better than did the statutory description of Schedule II.

⁶⁹Id at 36125.

⁷⁰~ at 36125—36126.

⁷¹sections III and IV of the secretary's review presented data about the statutory criteria, without evaluating that data with reference to the scheduling determination at hand. Only in section V did the secretary address the petition for rescheduling, and this section does not address any of these substantive criteria except medical use..I`.

The only other line of reasoning provided by Califano was that since Congress itself placed marijuana in Schedule I, ... arguments for placement in Schedule II must be stronger than those for placement in Schedule I to justify rescheduling.⁷² This position proves particularly noteworthy in light of the Act's legislative history, which clearly reveals Congress' uncertainty about marijuana scheduling and its hope that the issue would be reevaluated when more evidence arose⁷³, and which thus suggests that Congress did not want its initial scheduling decision to be perceived as a presumptively accurate or binding precedent. Nonetheless, it served as partial support for the Secretary's strong recommendation that all substances in question remain in Schedule I.

On the basis of both the Secretary's evaluation as well as his own perception of the Act's requirements, the DEA Administrator once again concluded that marijuana and synthetic THC should remain in Schedule I, and declined to take any further action on the petitioners' behalf.⁷⁴ As DEA Administrator Bensinger wrote, not only was he unable to determine that there exists substantial evidence to warrant the proposed change, but to the contrary, the evidence supports and mandates that marijuana and synthetic THC be maintained in Schedule I.

⁷² ~ at 36127.

⁷³H.R. Rep. No. 91-1444, ~ note 20.

7444 Fed. Reg. 36123, ~ note 66. at 36124.

But the battle continued, as NORML soon challenged this conclusion in the D.C. Circuit. Although the opinion⁷⁶ was an unpublished disposition that could not be cited as precedent⁷⁷, the court did not accept the DEA's conclusions, and ordered the case remanded to DEA for reconsideration in light of NORML's arguments regarding medical uses of the substances at issue. The court instructed DEA to refer all substances at issue to HHS for medical and scientific findings⁷⁸

As discussed above, since this matter was in the purview of the FDA's expertise, HHS transferred the issue on to that agency under its authority. Consequently, in 1982, the FDA issued two statements of proposed scheduling recommendations, one regarding marijuana and its components, and the other addressing synthetic THC.⁷⁹ In presenting its recommendation based on the scientific and medical aspects of marijuana, the FDA considered the factors for scheduling determinations set forth in the Controlled Substances Act, with regard to each of three categories of substances:

cannabis and cannabis resin, cannabis leaves, and cannabis seeds capable of germination. FDA noted that the term marijuana as addressed in the notice did not include

no. 79-1660 (D.c. cir., October 16, 1980).

⁷⁷Rule 11(c), 13, Digest of United States courts of Appeals' Rules, vol. 21 (1992).

⁷⁸47 Fed. Reg. 28141, 28142 (1982)

⁷⁹47 Fed. Reg. 10080 (1982) addressed synthetic THC, while 47 Fed. Reg. 28141 (1982) addressed marijuana and its components.

certain other extracts from the plant, including seeds incapable of germination.⁸⁰

In concluding that all three categories of marijuana products belonged in Schedule I, FDA devoted most of its focus to the issue of accepted medical usage. FDA interpreted the term accepted medical use to mean lawfully marketed under the Federal Food, Drug, and Cosmetic Act⁸, and found that none of the substances at issue fit that definition, primarily because there had been no approval of an NDA for any of them. FDA also rejected the idea that the substances could meet the schedule II criterion of having a currently accepted medical use with severe restrictions, holding that although this clause is not defined in the statute or legislative history, the agency believes that only certain investigational drugs in the later stages of the investigational process may fall within this statutory language.⁸² FDA asserted that although many states had passed legislation authorizing limited use of marijuana in medical research, such use was not in the later stages of the investigational process,⁸³ as was the use of THC (discussed below). Based on this evaluation that marijuana lacked accepted medical use and that it met the other

⁸⁰FDA specified that such term [marijuana] does not include the mature stalks of such plant, fiber produced from such stalks (except the resin extracted therefrom), fiber, oil, or cake, or the sterilized seed of such plant which is incapable of germination. 47 Fed. Reg. 28141, ~ note 78, at 28143.

⁸¹~ at 28150.

⁸²~ at 28151.

⁸³~

scientific criteria for schedule I, FDA recommended that each of the substances at issue remain in schedule I ~

FDA also recommended that synthetic THC remain in Schedule II, although FDA allowed that the future approval of an NDA would provide sufficient reason for rescheduling THC at a later date. After detailing its scientific findings on THC, FDA discussed the requirements for each of the five schedules, and concluded that THC could reasonably be placed in either Schedule I or Schedule II. FDA strongly urged, however, that Schedule I status be maintained until the approval of an NDA for synthetic THC.

In support of this THC recommendation, FDA applied in 1982 the same Congressional-precedent argument used by DEA in 1979~, an approach that was not used in the 1982 FDA notice on marijuana itself, discussed above. FDA claimed that where discretion is involved, the status quo created by Congress should not be changed unless there are clear data requiring the change or identifiable benefits to be gained by such change.⁸⁶ As discussed earlier, Congress did not intend for its initial and tenuous scheduling decision to receive such deference.⁸⁷

FDA did, however, suggest that rescheduling THC to Schedule II would be expedient once an NDA were approved for the drug,⁸⁸ and FDA noted that an NDA had been under

~ at 28152.

8544 Fed. Reg. 36123, ~ note 66.

8647 Fed. Reg. 10080, ~ note 79, at 10086.

⁸⁷H.R. Rep. No. 91-1444, ~ note 20.

8847 Fed Reg 10080, ~ note 79, at 10084.

consideration for an antinausea indication since June 25, 1981.⁸⁹ FDA explained that approval of such an NDA would provide the regulatory and scientific reason for rescheduling that otherwise remained absent.⁹⁰ FDA further explained that an NDA would provide an accepted medical use for THC, thus rendering Schedule II the appropriate classification for the drug at such a future time.⁹¹ Consequently, FDA proposed to recommend that THC remain in schedule I until an NDA is approved, ... and to conclude that THC not be rescheduled to schedule II unless and until an NDA is approved for marketing of THC.⁹²

Three years later, the FDA approved such an NDA for synthetic THC,⁹³ and DEA responded by rescheduling the drug (Dronabinol) to Schedule II in 1986.⁹⁴ The Administrator explained that his rescheduling was based on the scientific and medical evaluation and recommendation of the Assistant Secretary for Health and Human Services and on the Food and Drug Administration approval of a new drug application, but that it must meet international obligations.⁹⁵

With regard to international obligations, although synthetic THC was not included in the Single Convention on Narcotic Drugs, DEA noted that the substance was controlled

⁸⁹ at 10081.

⁹¹ at 10084.

⁹² at 10086.

⁹³ 21 CFR § 1308; para. 79,051 and 80,862, Food, Drug, and cosmetic Law

~ vol. 2.

⁹⁴ 51 Fed. Reg. 17476 (1986)

by the Convention on Psychotropic Substances,⁹⁷ which had become effective for the United States in July 1980.⁹⁸ In approving the rescheduling of Dronabinol to Schedule II, DEA sought to insure compliance with that Convention's mandate that parties prohibit all use except for scientific and very limited medical purposes,⁹⁹ by applying special restrictions to Dronabinol that did not apply to Schedule II drugs generally.¹⁰⁰ DEA set forth a policy stating that:

any person registered by DEA to distribute, prescribe, administer or dispense controlled substances in Schedule II who engages in the distribution or dispensing of Dronabinol for medical indications outside the approved use... except within the confines of a structured and recognized research program, may subject his or her controlled substance registration to review... as being inconsistent with the public interest. DEA will take action to revoke that registration if it is found that such distribution or dispensing constitutes a threat to the public health and safety, and in addition will pursue any criminal sanctions which may be warranted.¹⁰¹

DEA found this policy necessary in response to its observation that practitioner registrants frequently abused their license to prescribe other Schedule II drugs, by prescribing them for unapproved uses. Such abuses, the DEA Administrator asserted, must be avoided with particular

⁹⁶Id

⁹⁷Convention on Psychotropic substances, July 15, 1980, T.I.A.5. No. 9725.

⁹⁸51 Fed. Reg. 17476, 17477, note 94, at 17477.

⁹⁹General FDA policy is that all unapproved uses of approved drugs are lawful if the prescribing physicians deem such uses to be sound medical practice. FDA Drug Bulletin, October 1972, Rockville MD. This policy states, FDA is charged with the responsibility for judging the safety and effectiveness of drugs and the truthfulness of their labeling. The physician is then responsible for making the final judgment as to which if any of the available drugs his patient will receive in the light of the information contained in their labeling and other data available to him.

¹⁰⁰51 Fed. Reg. 17476, 17477, note 94, at 17477.

diligence in the case of Dronabinol, because of the United States' treaty obligation. With the special protective policy, the Administrator concluded that the Convention's obligations would be satisfied, and thus he formally moved Dronabinol to Schedule 11.101 The Federal Register announcement took no action, however, on the rescheduling of marijuana itself.

Later the same year, DEA issued another Federal Register statement, announcing a hearing on the NORML petition for rescheduling marijuana.⁰² The D.C. Circuit Court's 1980 remand had required DEA reconsideration and DHHS recommendations,⁰³ and although DHHS (through the FDA) had issued recommendations regarding both marijuana and synthetic THC in 1982, DEA itself had not yet responded to the court's remand of the marijuana issue. Since that court decision, DEA had issued a Federal Register announcement on THC, but not on marijuana itself. Thus, DEA announced in the Federal Register that a hearing would be held in August 1986, pursuant to the APA procedures set forth in 5 USC 556. The announcement reiterated that FDA and HHS had recommended that marijuana remain in Schedule I.1~

During the preliminary prehearing stage of proceedings, NORML filed an amended petition, changing its request from a call for complete descheduling or Schedule V rescheduling, to a petition only for a move to Schedule II. At a prehearing

101~ at 17478.

~51 Fed. Reg. 22946 (1986)

v. DEA, No. 79-1660.

10451 Fed. Reg. 22946, ~ note 102, at 22946-22947.

conference on February 20, 1987, the parties stipulated that marijuana has a high potential for abuse and psychological or physical dependence, and they agreed on two issues that the administrative law judge should address in determining whether a transfer of marijuana from Schedule I to Schedule II would be legal. These issues were:

(1) Whether the marijuana plant has a currently accepted medical use in treatment in the United States, or a currently accepted medical use with severe restrictions.

(2) Whether there is a lack of accepted safety for use of the marijuana plant under medical supervision. 105

Subsequently, the parties prepared and assembled their cases, and Administrative Law Judge Francis Young heard oral argument on the matter on June 10, 1988.¹⁰⁶

On September 6, 1988, Judge Young issued his decision recommending a rescheduling of marijuana to Schedule II.¹⁰⁷ Judge Young focused on two pivotal issues: whether marijuana had a currently accepted medical use in treatment in the U.S., and whether there was a lack of accepted safety for use of the marijuana plant under medical supervision.¹⁰⁸ In his decision, Judge Young discussed the strong evidence that marijuana had a widely accepted medical use in the treatment of chemotherapy side-effects. He detailed the evidence of oncologists nationwide acknowledging and advocating the effectiveness of marijuana in relieving the painful and often

¹⁰⁵In the *Matter of Marijuana Rescheduling Petition*, unpublished opinion, U.S. Department of Justice, Drug Enforcement Agency, Administrative Law

Judge Francis L. Young, September 6, 1988, Docket No. 86-22, 6.

¹⁰⁶~

at 68.

at 7.

life-threatening side-effects of cancer treatment, and he concluded that:

From the uncontroverted facts it is clear beyond any question that many people find marijuana to have, in the words of the Act, an accepted medical use in treatment in the United States in effecting relief for cancer patients. Oncologists... accept this. Other medical practitioners and researchers accept this. Medical faculty professors accept it. Nurses performing hands-on patient care accept it. 109

The judge acknowledged that it is impossible to determine if all, or even 51 percent, of the medical community shares these views, but he invoked the respectable minority standard used by courts in malpractice actions, whereby a procedure is acceptable if a respectable minority of physicians would find it so.¹¹⁰ He concluded that [t]he record here establishes conclusively that at least a 'respectable minority' of physicians has 'accepted' marijuana as having a 'medical use in treatment in the United States.'¹¹¹ The judge specified that the Act's criterion was whether an accepted medical use did exist, rather than whether it should exist, and thus concluded that this evidence should be dispositive.¹²

Finally, the judge stated that DEA should not be guided by FDA-type criteria in the case of marijuana, because marijuana is not a new drug (as it has been in use for centuries) and because its ease of cultivation means that no pharmaceutical company has incentive to invest the money in

109.I~ at 26.

at 27-29.

111.~ at 29.

112~ at 32.

the testing necessary for FDA approval. The judge therefore held that the Agency should not be influenced by FDA’S recommendation, although he did not account for the apparent contradiction between this suggestion to ignore FDA, and the HHS authority delegated to FDA under 21 CFR, which DEA was statutorily instructed to heed. Ignoring this seemingly implicit legislative foreclosure of his suggestion, Judge Young focused on the normative rationale for his suggestion, stating that:

Since the substance being considered in this case is a natural plant rather than a synthetic new drug, it is unreasonable to make FDA-type criteria determinative of the issue..., particularly so when such criteria are irrelevant to the question posed by the Act: Does the substance have an accepted medical use in treatment?¹¹³

Addressing this prescribed question, the judge held that marijuana clearly had a currently accepted medical use, and that. [t]o conclude otherwise, on this record, would be unreasonable, arbitrary and capricious.¹¹⁴

The judge also considered the evidence on marijuana’s use in treating glaucoma, spasticity resulting from such causes as multiple sclerosis, and hyperparathyroidism. Regarding glaucoma, Judge Young concluded that although some opthamologists testified to the effectiveness of such treatment, the evidence was insufficient to establish that their position was accepted by a respectable minority of physicians 115

113~ at 33—34.
114k at 34.
at 38—39.

116~ at 54.

117~

118l~. at 55.

However, the judge was persuaded that within the meaning of the Act, 21 U.S.C. 812 (b)(2)(B), marijuana 'has a currently accepted medical use in treatment in the United States' for spasticity resulting from multiple sclerosis and other causes.⁶ Judge Young held that enough evidence had been presented to establish that a significant minority of physicians do accept such treatment, and he concluded that Nothing more can be reasonably required. That some doctors would have more studies and test results in hand before accepting marijuana's usefulness here is irrelevant.⁷

Finally, Judge Young concluded that the evidence established an accepted medical use for treatment of hyperparathyroidism, an extremely rare condition resulting in bone spurs, great pain, and risk of cancer. Because of the rarity of the disease, Judge Young concluded that acceptance by one doctor of marijuana as being useful in treating it ought to satisfy the requirement for a significant minority. Young noted that the Agency had presented no evidence suggesting that marijuana was not accepted in treating this extremely rare disease. Consequently, Judge Young ruled that, as in the cases of chemotherapy and spasticity treatments, refusal to recognize acceptance [of marijuana use in treating hyperparathyroidism] by a significant minority., would be unreasonable, arbitrary and capricious. 118

The judge then addressed the second of the two questions slated for him: whether there is a lack of accepted safety for use of marijuana under medical supervision. Once again, the judge held that accepted meant *actual* acceptance by the medical community (at least a significant minority of it), and he found that the Agency was in error to focus on scientific studies and on whether doctors *should* accept such use. Thus, the judge asserted that the only proper question for the Agency here is: Is a significant minority of physicians accepting marijuana as safe for use under medical supervision?¹¹⁹ The record made clear, Judge Young concluded, that such acceptance did indeed exist. Moreover, Young held that this accepted safety of use extended to glaucoma treatment, even though the judge did not find that the use itself for that purpose was accepted. In analyzing the Agency's case against recognizing marijuana's accepted safety, Young concluded that the Agency's argument amounted simply to an assertion that more tests were needed. However, because the question was whether a significant minority did accept it, not whether they should, Young held that further tests were unnecessary as the standard had already been met.¹²⁰

Following his affirmative answers to both questions set forth for him, Judge Young concluded that the provisions of the Act permit and require the transfer of marijuana from Schedule I to Schedule II. Young urged the Agency not to be swayed from this objective analysis by the strong emotions

¹¹⁹ at 65.

¹²⁰ at 65-66.

aroused by the subject of marijuana.¹²¹ He also found specious the argument that rescheduling marijuana would 'send a signal' that marijuana is 'OK' generally for recreational use, and he urged that this misguided fear should not prevent marijuana from being placed in the legally appropriate schedule. Judge Young held that, because

marijuana has been accepted as capable of relieving the distress of great numbers of very ill people, and doing so with safety under medical supervision... [i]t would be unreasonable, arbitrary and capricious for DEA to continue to stand between those sufferers and the benefits of this substance in light of the evidence of this record. 122

Consequently, Judge Young recommended that the Administrator transfer marijuana from Schedule I to Schedule II.¹²³

But the DEA Administrator rejected Judge Young's recommended ruling in December 1989, and thereby denied NORML's petition once again.¹²⁴ In rejecting NORML's petition, the DEA Administrator detailed why he perceived Judge Young's conclusion to have been faulty. The DEA Administrator revisited the evidence upon which Judge Young had relied, and challenged it as anecdotal and unreliable.¹²⁵ Following his own review of the evidence, the Administrator found that

there is insufficient, and in many instances no, reliable, credible, scientific evidence, supported by properly conducted scientific research, to support a conclusion that marijuana has a medical use to treat any ailment or disease. In addition, there is a lack of scientific evidence to support a

¹²¹ at 67.
¹²² at 68.
¹²³
¹²⁴ 53767 (1989)
¹²⁵ at 53773.

conclusion that marijuana is safe for use under medical supervision. 126

The DEA Administrator claimed that Judge Young had failed to act as an impartial judge, as he appears to have ignored the testimony of highly-credible and recognized medical experts.¹²⁷ The DEA Administrator asserted that Judge Young ignored any evidence presented by the Government, by relying entirely on the physicians presented by the petitioners, and not once...mention[ing] the Government's experts. 128

The DEA Administrator accused Judge Young of develop[ing] his own standard for both accepted medical use and accepted safety.¹²⁹ The Administrator rejected Judge Young's standard of a significant or respectable minority as preposterous because, as he stated, using the same criteria as medical malpractice cases to determine a national standard of medical acceptance is untenable, since the views of those few physicians and scientists [who deviate from the norm] are not sufficient to create a finding of national acceptance.¹³⁰ In place of Judge Young's standard, the DEA Administrator applied an eight-part test to determine if there was an accepted medical use for marijuana.¹³¹ The factors that it set forth to determine medical acceptability were: (1) scientifically determined and accepted knowledge of

126~I.~ at 53772.

127~ at 53782.

128.I.~ at 53782-53783.

129~ at 53783.

130~ at 53784.

~ The Administrator had fist developed this test of accepted medical usage as a response to Grinspoon v. DEA, 828 F. 2d 881 (1987).

its chemistry; (2) the toxicology and pharmacology of the substance in animals; (3) establishment of its effectiveness in humans through scientifically designed clinical trials; (4) general availability of the substance and information regarding the substance and its use; (5) recognition of its clinical use in generally accepted pharmacopoeia, medical references, journals or textbooks; (6) specific indications for the treatment of recognized disorders; (7) recognition of the use of the substance by organizations or associations of physicians; and (8) recognition and use of the substance by a substantial segment of the medical practitioners in the United States. Based on this test, as applied to his review of the evidence (discussed above), the Administrator concluded that, without reliable scientific studies, there was insufficient medical and scientific evidence to support a conclusion that marijuana has an accepted medical use for treatment of any condition, or that it is safe for use, even under medical supervision.³² Consequently, the Administrator denied NORML's petition and ordered that marijuana remain in Schedule I.³³

But the battle between DEA and NORML was far from over. By 1991, it had come full circle once more, as NORML petitioned the court for review of DEA's decision.³⁴ The D.C. Circuit held that the DEA Administrator was well within his power to reject the administrative law judge's respectable

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³² Alliance for cannabis Therapeutics and NORML v. DEA, 930 F. 2d 936 (D.C. cir. 1991)

at 940.

minority standard. The court found appropriate the Administrator's reliance on the lack of scientific evidence regarding marijuana. The court cited 21 USC 811 (c) (2) and

(3) in stating that Congress required the Administrator, in

making scheduling determinations with respect to the drug, to consider the 'scientific evidence of [the drug's] pharmacological effect' and the 'state of current scientific knowledge regarding the drug.' The court did not find that the administrative law judge's recommendation was wrong, but simply held that the Administrator's rejection of it was acceptable, as the court concluded that it was very much a policy judgment which we have no authority to challenge.³⁵

However, the court did adopt one of petitioners arguments, which ultimately unraveled the court's acceptance of the Administrator's decision and led to a remand for explanation. The court accepted NOEML's argument that three of the eight factors in the Administrator's test might be impossible to satisfy precisely because of the drug's Schedule I classification. Factors 4 (general availability of the substance and information regarding the substance and its use), 5 (recognition of its clinical use in generally accepted pharmacopoeia, medical references, journals or textbooks) and 8 (recognition and use of the substance by a substantial segment of the medical practitioners in the United States), all described circumstances which would only be legal for drugs in Schedule II or higher, and thus the

court questioned their validity for determining whether a Schedule I drug *should* be in Schedule II. Because the court could not determine how strongly these three factors had influenced the Administrator's decision, the court remanded the case for an explanation as to how all three of these factors were utilized by the Administrator in reaching his decision. 136

In response to the court's remand, DEA issued a statement in 1994, once again concluding the plant material marijuana has no currently accepted medical use and denying the petition of NORML.¹³⁷ The Administrator (successor to the author of the 1989 decision which had been at issue in the 1991 D.C. Circuit case) based this statement on his own analysis of the evidence, concluding that further hearings were unnecessary in light of such an extensive record. In addressing the court's concern over the standards used by his predecessor, the Administrator labeled marijuana bad medicine by any standard. He subdivided the three factors concerning the Court as follows: (4) (a) general availability of the substance, (4) (b) general availability of information regarding the substance and its use, (5) recognition of its clinical use in generally accepted pharmacopoeia, medical references, journals or textbooks, (8) (a) recognition of the substance by a substantial segment of the medical practitioners in the United States, and (8) (b) use of the

136⁷ at 940—941.

13757 Fed. Reg. 10499 (1994)

substance by a substantial segment of the medical practitioners in the United States.

The Administrator's analysis ultimately presented a five-part test to replace the initial eight-part test, but this new test eliminated only factors (4) (a), (5), and (8) (b). With regard to factor (4) (a), the Administrator accepted the Court's position that requiring a material history of past use in treatment before recognizing a drug as having a currently accepted medical use.., would permanently freeze all Schedule I drugs into Schedule I,~138 and thus he rejected this criterion. Likewise, he essentially eliminated factor (8) (b) as well, as he proposed that factors (7) and (8) be combined and restated as requiring either that the drug has an FDA-approved New Drug Application (NDA) or:

a consensus of the national community of experts, qualified by scientific training and experience to evaluate the safety and effectiveness of drugs, accepts the safety and effectiveness of the substance for use in treating a specific, recognized disorder. A material conflict of opinion among experts precludes a finding of consensus 139

This restated requirement eliminates the factor (8) (b) requirement of use.. by a substantial segment of medical practitioners in the United States. The Administrator expressed certainty that factors 4(a) and 8(b) played no role in the previous administrator's decision.'~

Regarding factor (5), the Administrator held that recognition in generally accepted texts is irrelevant as

138~	at	10506.
139~	at	10505.
140~	at	10507.

long as information about the drug's chemistry, pharmacology, toxicology and effectiveness are available as required by factors (1) and (4). Beyond those requirements, the Administrator not only found factor (5) irrelevant, but he also declared that to the extent the scheduling of a drug directly influences its recognition in publications, this element is subject to the same criticism identified by the Court... concerning point four (i.e.: that it would freeze Schedule I drugs in Schedule I]. Based on this, the Administrator held that factor (5) should not be treated as a distinct requirement 141 Because his predecessor had explicitly noted that factor (5) was not met, the Administrator could not dismiss it as having played no role in his predecessor's decision, as he did with factors (4) (a) and (8) (b). Instead, the Administrator viewed his predecessor's mention of factor (5) through the lens of his own revised conception of its appropriate scope. Thus, the Administrator interpreted his predecessor's noting that factor (5) was not met, to mean only that his predecessor determined that marijuana's chemistry is neither known, nor reproducible, as evidenced by its absence from the official pharmacopoeia. 142

Regarding the remaining criterion in question, the Administrator stated that the factor (4) (b) requirement of general availability of information should be clarified to read that:

141~ at 10506.

142~

Information concerning the chemistry, pharmacology, toxicology and effectiveness of the substance must be reported, published, or otherwise widely available, in sufficient detail to permit experts, qualified by scientific training and experience to evaluate the safety and effectiveness of drugs, to fairly and responsibly conclude the substance is safe and effective for use in treating a specific, recognized disorder.¹⁴³

Essentially, this restatement of factor (4) (b) is a compilation of factors (1) (knowledge of its chemistry), (2) (toxicology and pharmacology), (3) (effectiveness), and (6) (indicated for the treatment of a specific, recognized disorder), all of which had been upheld by the court.

Based on this analysis, the Administrator set forth a revised five-factor test to replace his predecessor's eight-factor test. As explained above, this test eliminated some of the factors that had troubled the court (4a, 5, and 8b), while maintaining others (4b and 8a) with revised wordings and explanations of why they met the court's concerns. The new five-factor test specifically defined the basic requirements it set forth, providing as follows:

(1) The Drug's Chemistry Must Be Known and Reproducible (The substance's chemistry must be scientifically established to permit it to be reproduced in dosages which can be standardized. The listing of the substance in a current edition of one of the official compendia, as defined by section 201(j) of the Food, Drug and Cosmetic Act, 21 USC 321(f), is sufficient generally to meet this requirement.)

(2) There Must be Adequate Safety Studies (There must be adequate pharmacological and toxicological studies done by all methods reasonably applicable on the basis of which it could fairly and responsibly be concluded, by experts qualified by scientific training and experience to evaluate the

143~

at **10507**.

safety and effectiveness of drugs, that the substance is safe for treating a specific, recognized disorder.)

(3) **There Must Be Adequate and Well-Controlled Studies Proving Efficacy** (There must be adequate, well-controlled, well-designed, well-conducted and well-documented studies, including clinical investigations, by experts qualified by scientific training and experience to evaluate the safety and effectiveness of drugs on the basis of which it could fairly and responsibly be concluded by such experts, that the substance will have its intended effect in treating a specific, recognized disorder.)

(4) **The Drug Must Be Accepted by Qualified Experts**

(The drug must have a New Drug Application (NDA) approved by the Food and Drug Administration... Or, a consensus of the national community of experts, qualified by scientific training and experience to evaluate the safety and effectiveness of drugs, accepts the safety and effectiveness of the substance for use in treating a specific, recognized disorder. A material conflict of opinion among experts precludes a finding of consensus.)

(5) **The Scientific Evidence Must Be Widely Available** (In the absence of NDA approval, information concerning the chemistry, pharmacology, toxicology and effectiveness of the substance must be reported, published, or otherwise widely available in sufficient detail to permit experts, qualified by scientific training and experience to evaluate the safety and effectiveness of drugs, to fairly and responsibly conclude the substance is safe and effective for use in treating a specific, recognized disorder.)

As stated previously, the Administrator expressed conviction that his predecessor had not been influenced by any of the factors that the present Administrator found inappropriate. However, the Administrator conceded that he could not fully know his predecessor's unstated reasoning, and thus the Administrator explained, I have reviewed the entire record de novo, and I am convinced that... marijuana has no currently accepted medical treatment in the United States.'

Referring to his revised criteria, the Administrator stated that a failure to meet just one of the five points precludes a drug from having a currently accepted medical use, and he concluded that marijuana fails all five points of the test.¹⁴⁵ Consequently, the Administrator ordered that marijuana remain in Schedule ~

For the first time, in its 1994 opinion in Alliance for Cannabis Therapeutics and NORML v. DEA, the D.C. Circuit did not remand the Administrator's decision in response to petitioners' appeal, but instead supported the Administrator's conclusions and thereby gave them full force of law. The court refused to revisit the issue of whether the Administrator's basic interpretation of the statute was reasonable, based on the law of the case doctrine that made binding the court's ruling on that issue in the 1991 case.¹⁴⁷ The court rejected petitioners' contention that the court had not given adequate attention to the statutory interpretation issue previously, and asserted that, regardless, even summarily treated issues become the law of the case. Thus, the court reiterated its previously stated position on the statutory interpretation issue, that it was not 'an unreasonable application of the statutory phrase [for the

~45~

'~I~' at 10508.

¹⁴⁷Alliance for cannabis Therapeutics and NORML v. DEA, 15 F. 3d 1131, 1134 (D.c. cir. 1994. The court explains that the law of the case doctrine dictates that barring exceptional circumstances, appellate courts do not reconsider matters resolved on a prior appeal in the same proceeding, citing 18 Wright & Miller, Federal Practice and Procedure § 4478 (1981)

Administrator] to emphasize the lack of exact scientific knowledge as to the chemical effects of the drug's elements. '49

Consequently, the court focused on the Administrator's response to the issue on which it had remanded: the three questionable factors. The court accepted the Administrator's conclusion that his predecessor's decision had not been based on those criteria that a Schedule I drug would be barred from meeting precisely because of its scheduling. The court also found acceptable the new five-factor test presented by the Administrator, as it concluded that none of these criteria is impossible for a Schedule I drug to meet.⁴⁹

Finally, the court also rejected wholesale the petitioners' two additional claims, which had not been part of the court's 1991 opinion. Petitioners claimed that the previous Administrator had violated the Freedom of Information Act (FOIA) by not disclosing his eight-factor test in time for petitioners to conform their evidentiary submissions to it, and that the Administrator did not engage in reasoned decisionmaking because he was biased and ignored the record. Regarding the FOIA claim, petitioners claimed that the Administrator had violated section 552 (a) (1) of FOIA, which requires agencies to set out in advance the legal standards that will be applied so that parties may

⁴⁹Alliance for cannabis Therapeutics and NORML v. DEA, 15 F. 3d at 1135, citing Alliance for cannabis Therapeutics and NORML v. DEA, 930 F. 2d at 939.

⁴⁹Alliance for cannabis Therapeutics and NORML v. DEA, 15 F. 3d at 1135.

plan and act accordingly.¹⁵ Although the Administrator had not published the eight-factor test until 17 days after the close of evidence, the court held that he had not violated FOIA, because in order to establish a claim under the statute... the litigant must show that 'he was adversely affected by a lack of publication or that he would have been able to pursue an alternative course of conduct' had the information been published.¹⁵ The court concluded that petitioners have failed to demonstrate that they have in fact been adversely affected by the lack of notice, and thus the court denied petitioners' request that the case be remanded to the Administrator with instructions that he reopen the record for new evidence. The court based its conclusion on the fact that during the nearly two years between the publication of the eight-factor test on February 22, 1988, and the Administrator's ruling on December 29, 1989, petitioners never sought to reopen the record. The court found this to suggest that either petitioners were satisfied with the evidence in light of the new test, or that they had no additional evidence to offer. Consequently, the court concluded, we have no reason to believe that petitioners would have pursued an 'alternative course of conduct' had the test been published earlier.¹⁵²

150.I.~. at 1136, citing 5 usc § 552(a) (1).

¹⁵Id. citing Zaharakis v. Heckler, 744 F. 2d 711, 714 (9th cir. 1984).

It is puzzling that in setting forth this adversely affected limitation on FOIA violations, which proves pivotal for the issue here, the court cites as its only support a case from the Ninth circuit. 152~~ at 1136, citing Zaharakis v. Heckler, 744 F. 2d at 714.

In responding to petitioners' reasoned decisionmaking claim, the court confined its analysis to the current Administrator, since the court had already remanded the issue of the previous Administrator's decisionmaking to the agency. The court held that the need to remand a case several times is not evidence per se of agency prejudice. Further, the court found reasonable the Administrator's preference for rigorous scientific proof over anecdotal evidence, even when reported by respected physicians, as such was consistent with the reasonable view that only rigorous scientific proof can satisfy the CSA's [Controlled Substances Act's] 'currently accepted medical use' requirement.¹⁵³ In addressing the record itself, the court concluded that the Administrator's findings are supported by substantial evidence, as required by 21 U.S.C. 877.'~ The court held that it was reasonable for the Administrator to accord more weight to the opinions of... experts than to the anecdotal testimony of laymen and doctors on which petitioners relied, Concluding that the Administrator's decision was not biased, and that it met the substantial evidence standard, the court denied all of petitioners claims, fully upheld the Administrator's decision and, for the first time, did not remand any part of it for further consideration.¹⁵⁵

¹⁵³Alliance for cannabis Therapeutics and NORML v. DEA, 15 F. 3d at 1137.

~ citing 21 usc § 877 (1988), which states that the substantial evidence standard applies to findings of fact in rescheduling proceedings.

¹⁵⁵Alliance for cannabis Therapeutics and NORML v. DEA, 15 F. 3d at 1137.

With this final chapter, NORML apparently exhausted its options for recourse under the Act's own provisions. However, the group has not accepted defeat; it has merely moved the battle to alternative fronts, where it has joined other individuals and groups also engaged in the struggle for medical marijuana use. Part III of this essay surveys the other avenues to change which NORML **and others are pursuing**, as alternatives to the statutorily prescribed path.

Part Three:
Beyond Statutorily Prescribed Channels:
Alternatives Avenues to Reform

Proponents of legalizing medical marijuana use have also sought their objective through channels other than the statutorily prescribed means of rulemaking petitions and judicial review. These alternative efforts at changing the laws have met with varying degrees of success, and many of them continue today. This discussion reviews the areas in which such initiatives have been launched, and addresses their evolving effectiveness from inception to the present. The first such alternative initiative involves the FDA Investigational New Drug (IND) program, which began supplying marijuana to a handful of ailing individuals in the 1970s. Because the Bush administration stopped accepting new patients to this project and the Clinton administration preserved this status, however, the only remaining

beneficiaries of this project are the eight individuals who were grandfathered into the program.

Next, this essay reviews state initiatives that have been undertaken towards allowing medical marijuana usage. In the judicial arena, some state courts have ruled that medical necessity is a valid defense against marijuana possession charges, thereby effectively legalizing medical marijuana usage within their borders. However, supply problems and the threat of prosecution remain even with such a defense, and thus some of these states as well as others have taken action in their state legislatures towards legalization of medical usage. These legislative actions range from non-binding statutory resolutions encouraging federal acceptance of medical marijuana, to substantive provisions legalizing its use.

Finally, proponents are presently working towards the alternative of federal legislative action. A bill currently before Congress proposes to legalize medical marijuana use under federal regulatory authority. The forthcoming discussion addresses the history and effects of the initiatives in each of the aforementioned areas.¹⁵⁶ This review not only illuminates the situation surrounding medical

¹⁵⁶Some have suggested that additional scientific study on the efficacy of medical marijuana would further bolster proponents' efforts towards legalization, and there is some evidence that the government has not been supportive of such research initiatives. However, the issue of scientific knowledge and research on marijuana is beyond the scope of this essay, which addresses reform initiatives in the legal and political arenas. Telephone interview with Mark Kleiman, Associate Professor of Public Policy, Kennedy school of Government, Harvard university (March 27, 1996).

marijuana use in particular, but also presents the range of options available to groups and individuals seeking change in the laws on other administrative issues and meeting with frustration along the legislatively prescribed channels.

***Medical Marijuana AcCeUB through the
Federal Investigational New Drug Program***

The federal supplying of medical marijuana through the FDA IND program, an initiative which currently provides eight people with the drug, began in 1978, as part of a settlement from a lawsuit filed against the government by medical user Robert Randall.¹⁵⁷ Randall's legal action against the government followed his acquittal on marijuana possession charges in 1976, on the grounds of medical necessity.¹⁵⁸ Randall was diagnosed with glaucoma in the early 1970s, and was told by doctors that he would be blind within a few years.¹⁵⁹ He discovered that marijuana eased the pressure on his eyes, and consequently he began using it daily. In August of 1975, Randall was arrested for marijuana possession. He underwent a battery of tests by independent researchers, which concluded that he would go blind without the drug.¹W Bolstered by such strong medical testimony,

¹⁵⁷Randall v. U.S. (1978), discussed in Affidavit of Robert C. Randall, May 20, 1987, in Marijuana, Medicine and the Law 27-28 (R.C. Randall, ed., 1988). See ~ 60 Minutes: Smoking to Live (CBS News Television Broadcast, December 1, 1991). Eugene L. Meyer, uncle Sam's Aunt Mary; In Which We Pay a Visit to a Far-Out Place: The U.S. Government Pot Plantation, The Washington Post, October 22, 1995, at FOI. ¹⁵⁸United States v. Randall, No. 65923-75 (D.C. Super. Ct. filed Nov. 24, 1976), reported in The Daily Washington Law Reporter, vol. 104, Dec.

28, 1976, 2239—2254.

¹⁵⁹U.S. v. Randall, The Daily Washington Law Reporter, vol. 104, at 2249.
~ **L.A. Times, Oct. 22, 1995.**

I⁶OTJg v. Randall, The Daily Washington Law Reporter, vol. 104 at 2249.

Randall was acquitted in 1976, on grounds of medical necessity. 161

The RⁿIJ. court identified the case as one of first impression, and reached its conclusion through an analysis of the common law defense of necessity. The court recognized that the common law necessity doctrine justified or excused conduct that the actor did not have a free choice in taking due to extraordinarily compelling circumstances. The court noted, however, that the necessity defense is not available under such circumstances if any of the following limitations exists: (1) The actor caused the compelling circumstances leading to his/her action; (2) The same objective could have been met through a less offensive alternative available to the actor; ^r (3) The harm avoided was less heinous than the actor's conduct to avoid it.⁶²

The court applied these criteria to Randall's case, and concluded that Randall's glaucoma was a sufficiently compelling circumstance to excuse his marijuana use in accordance with the necessity defense, since conventional medications and surgery offer little hope of improvement [and] ... the inhalation of marijuana smoke has a beneficial effect on his condition. Further, the court held that Randall's use did not fall within the three common law limitations on the defense, because Randall did not cause his glaucoma, he had no equally effective alternative to marijuana, and the court concluded that the harm to society

at 2254.

162^r at 2252.

of allowing such use was less than the benefit to Randall. In discussing the latter of these three factors, the court analogized the case at bar to the U.S. Supreme Court's decision in Roe v. Wade,¹⁶³ as both cases weighed the right of an individual to protect his body... against the interest of the government in guarding the health and morals of the general public.'~ The court stated that fl.~ and other cases revealed how far-reaching is the right of an individual to preserve his health and bodily integrity. On this basis, the court concluded that the evil he [Randall] sought to avert, blindness, is greater than that he performed to accomplish it, growing marijuana in his residence.¹⁶⁵ Thus, the court found that Randall's circumstances fulfilled the necessity defense, and that he did not fit into any of the three limitations on its availability. Consequently, the court held that defendant Robert C. Randall has established the defense of necessity, and found him not guilty.'~

The court's application of the necessity defense to medical marijuana use was the first such judicial holding, and it led Randall to seek further recognition of his medical marijuana needs. Following his acquittal, Randall filed suit against the federal government.¹⁶⁷ The lawsuit settled out of court in 1978, with Randall becoming the first marijuana

⁶³Roe v. Wade, 410 u.s. 113 (1973).

'~u.s. v. Randall, The Daily Washington Law Renorter, vol 104, at 2253. at 2253.

at 2254.

¹⁶⁷Randall v. u.s. (1978), discussed in Affidavit of Robert c. Randall,

May 20, 1987, in Mariluana. Medicine and the Law, ~ note 157, at 27-28.

recipient under the FDA IND program.¹⁶⁹ The IND program exists under section 505(i) of the Federal Food, Drug, and Cosmetic Act, which enables the FDA to authorize limited use of drugs that are not yet fully tested.¹⁷⁰ In Randall's case, the National Institute on Drug Abuse (NIDA), a subsidiary to the Public Health Service, was the applicant for the IND, which FDA authorized.¹⁷⁰

NIDA already had a legal supply of marijuana from which it was able to supply Randall. Under a research contract with the University of Mississippi's Research Institute of Pharmaceutical Sciences, NIDA funded a project that grew marijuana in order to conduct research on its chemistry. This project, called the M-Project, began in 1968 when pharmaceutical researcher Dr. Coy Waller won a contract from the National Institute of Mental Health (NIMH) to establish the program at the University of Mississippi.¹⁷¹ Following Congressional passage of the 1972 Act creating NIDA as a subsidiary body within NIMH,¹⁷² authority over the M-Project was delegated to NIDA.¹⁷³ When Congress removed NIDA from NIMH's authority and placed it under the Alcohol, Drug Abuse,

¹⁷⁰Telephone interview with Don McClearn, Deputy Associate commissioner for Public Affairs at the FDA (March 22, 1996). According to McClearn, all IND files are confidential, so Randall's file number cannot be released publicly.

¹⁶⁹The Federal Food, Drug, and cosmetic Act of 1938 § 505(i), 21 usc §**355(i)** (1994).

¹⁷⁰Telephone interview with Cheryl Messera, Press Officer at NIDA (April 10, 1996). **Telephone interview with Don McClearn, ~ note 168.**
As

mentioned above, McClearn stated that all IND files are confidential and that therefore Randall's file number cannot be released publicly.

¹⁷¹Telephone interview with Dr. Coy Waller, Founder of the M-Project (April 10, 1996)

¹⁷²The Drug Abuse Office and Treatment Act of 1972, Pub. L. 92-255, §501, 86 Stat. 65, 85 (1972).

¹⁷³Telephone interview with Cheryl Messera ~ note 170.

and Mental Health Administration (ADAMHA) two years later,¹⁷⁴ NIDA maintained control over the M-Project.¹⁷⁵ The project remains under contract with NIDA today, and in addition to providing a limited amount of medical marijuana, it also continues to function in a law-enforcement capacity by analyzing the content of suspected marijuana for police departments nationwide.¹⁷⁶

From this M-Project, NIDA began supplying Randall with marijuana in 1978, pursuant to FDA's authorization.¹⁷⁷ Randall's situation set a medical-use precedent which many other individuals sought to follow. However, the process for a doctor to enroll a patient in the program was quite time-consuming, requiring approximately 50 hours of paperwork according to one doctor's calculation.¹⁷ Towards the end of the 1980s, with the spread of the AIDS virus, a strong interest in medical use of marijuana for treatment of the AIDS wasting syndrome emerged.¹⁷⁹ In response, Randall

¹⁷⁴comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act Amendment of 1974, Pub. L. 93-282, § 204, 88 Stat. 125, 136 (1974)

¹⁷⁵Telephone interview with Cheryl Messera, supra note 170.

¹⁷⁶Meyer, ~ note 157, at FOI.

¹⁷⁷Telephone interview with Cheryl Messera, ~ note 170. Telephone interview with Don Mcclern, supra note 168. As mentioned above, Mcclern stated that all IND files are confidential and that consequently Randall's file number cannot be released publicly. ¹⁷⁸Richard Paddock, Is smoking Pot Good Medicine?, Los Angeles Times, February 26, 1995, at A1. See ~ Statement by u.s. Public Health service, March 6, 1992 (on file with the DHHS Press Office). According to this statement, in addition to seeking access to the IND program, physicians were required to comply with a rigorous DEA registration process.

¹⁷⁹Lester Grinspoon, M.D., Marijuana. The Forbidden Medicine 85-91 (1993). ~ Lester Grinspoon, Marijuana as Medicine: A Plea for Reconsideration, 273 Journal of the American Medical Association 1875

(1995). The AIDS wasting syndrome involves is caused by the progress appetite loss and nausea that often afflict AIDS patients, causing them to become dangerously underweight..L~.

assembled a how-to-apply kit, which he released to AIDS groups to facilitate patients' access to the federal program.¹⁸⁰ Applications by AIDS patients to the program rose dramatically, leading the Public Health Service (PHS) under the Bush administration¹⁸¹ to close the program. Assistant Secretary for Health James Mason, M.D., who headed PBS, put the program on hold in June 1991 in order to assess it. The final PBS decision to close the program was issued on March **6, 1992. From that point on, no new patients were admitted**, but NIDA continued to supply marijuana to the thirteen medical users already in the program.¹⁸² Of those thirteen, five have subsequently died of AIDS. Randall, however, continues to receive his supply of marijuana from NIDA, and contrary to doctors' projections that he would be blind by the mid-1970s, he still has his eyesight.¹⁸³

The Clinton administration considered lifting the ban in 1994, but decided against doing so.¹⁸⁴ Philip Lee, Assistant Secretary for Health under the Clinton Administration, explained that

¹⁸⁰Meyer, ~ **note 157, at FOI.**

¹⁸¹During the Bush Administration, the Public Health Service of DHHS had authority over FDA and over ADAMHA. As mentioned above, NIDA was an entity within ADAMHA. Statement by the U.S. Public Health Service, sunra note 178.

¹⁸²Statement by the U.S. Public Health Service, ~ note 178. See also John Bow-ersox, PHS cancels Availability of Medicinal Marijuana, 84 Journal of the National cancer Institute 475 (1992).

¹⁸³Paddock, ~ note 178, at A1.

¹⁸⁴Letter from Philip Lee, Assistant Secretary for Health, to u.s. Representative Dan Hamburg (July 21, 1994) (on file at the DHHS Press Office). See ~ Rebecca Voelker, Medical Marijuana: A Trial of Science and Politics, 271 Journal of the American Medical Association 1645 (1994).

In considering whether to reopen the single patient IND process [for marijuana] we have carefully evaluated the current state of knowledge about therapeutic marijuana. This evaluation indicated that sound scientific studies supporting these claims are lacking despite anecdotal claims that smoked marijuana is beneficial.¹⁸⁵

Consequently, Lee stated, the Public Health Service under Clinton will not reopen the single patient Investigational New Drug program for marijuana.¹⁸⁶

State Common Law:

Reception of the Medical Necessity Defense

The Washington, D.C. Superior Court's acceptance of the medical necessity defense in Randall, discussed above, led to similar decisions in state courts across the country. Indeed, in those states which have accepted it, the medical necessity defense has provided an important bypass around the rules against medical marijuana use. However, some states' courts that have considered the question have ruled that no such defense is available to the charge of marijuana possession. Finally, many states' courts have not yet confronted the issue, simply because cases in which a defense of necessity would likely be raised are seldom prosecuted.¹⁸⁷

¹⁸⁵Letter from Philip Lee to Dan Hamburg, ~3J note 184. ¹⁸⁶Id.

¹⁸⁷Arnolds and Garland, The Defense of Necessity in criminal Law: The Right to choose the Lesser Evil, 65 J. crim. L. & criminology 289, 290 (1974) (discussing the paucity of cases nationwide involving the necessity defense in general, and stating that this is probably because these cases are not often prosecuted.)

Following is a discussion of the positions taken by those states that have considered the issue.

Three years after the Washington, D.C., trial court decision in *B.~n~li*, the Washington State Court of Appeals also ruled that medical necessity is an affirmative defense to the charge of marijuana possession, in its 1979 opinion in *Washinaton v. Diana*.¹⁸⁸ In so doing, the Washington Court of Appeals became the first state appellate court to adopt the medical marijuana necessity defense as common law. The defendant, Samuel Diana, had been convicted in state trial court of marijuana possession, and appealed his conviction on several grounds.¹⁸⁹ Of Diana's contentions, the appellate court accepted only the claim that he should have been given an opportunity to present evidence supporting a medical necessity defense to his marijuana possession charges. The court remanded the case on that basis, holding that if Diana could prove the elements the court set forth for medical necessity (as discussed below) his conviction should be reversed. 190

Defendant Diana had been arrested in 1977, on charges of marijuana possession. At his initial trial, Diana testified that he suffered from multiple sclerosis, and that he used marijuana to ease his symptoms. However, Diana did not try

¹⁸⁸*State of Washington v. Samuel Diana*, 604 P. 2d 1312 (1979). ¹⁸⁹The other grounds for defendant's appeal, which are unrelated to the topic of this essay, involved the spousal privilege against testifying and the knock-and-wait rule of entering a home. The appellate court rejected Diana's claims on both of these issues, and accepted only Diana's contention that he should be permitted to present evidence supporting a medical necessity defense. I~.

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to mount a defense of medical necessity based on this information, and consequently, the trial judge, who sat as the trier of fact, did not enter a finding on this point.⁹¹ On appeal, Diana sought to raise a defense of medical necessity, based on three factors: (1) his experience of symptom relief through marijuana was supported by current medical research; (2) the drugs his doctors legally prescribed were not as effective as marijuana at relieving his symptoms, and they had unpleasant side effects; and (3) he tried to obtain marijuana legally through his physicians, and they refused his request solely on the basis of the drug's illegality.⁹²

The prosecution argued against Diana's introducing this new defense at the appellate level, citing the general rule that an appellate court will not consider arguments that have not first been presented to the trial court.⁹³ However, the appellate court determined that the circumstances of this case justified an exception to this general rule, based on appellate courts' discretion to take any action required by the merits of the case and the interests of justice.⁹⁴ The court noted that information on the potential therapeutic use of marijuana had been widely publicized in the short interim since Diana's trial, leading the court to the

⁹¹ at 1315.

⁹² id.

⁹⁴ at 1315 n.3, citing Rules of Appellate Procedure 12.2 that The appellate court may reverse, affirm, or modify the decision being reviewed and take any other action as the merits of the case and the interest of justice may require.

conclusion that justice requires that we consider defendant's argument. 195

The court reviewed the elements of the general necessity defense,¹⁹⁶ as follows:

Generally, necessity is available as a defense when the physical forces of nature or the pressure of nature or the pressure of circumstances cause the accused to take unlawful action to avoid a harm which social policy deems greater than the harm resulting from a violation of the law.¹⁹⁷

The court also noted that the defense is not applicable where the compelling circumstances have been brought about by the accused or where a legal alternative is available to the accused. **'s198**

The court acknowledged that the medical necessity defense was not commonly applied to marijuana use, and that the *B'n'li* case was the only precedent for the *~* decision. The court praised the *~n~2J.* court's approach in balancing the defendant's interest in preserving his sight against the government's interest in controlling the drug, and approved of the opinion's placing special emphasis... upon the importance of an individual's right to preserve and protect his own body.¹⁹⁹ After reviewing the general necessity defense and the D.C. Superior Court's application of that defense to medical marijuana use in *B'n'li.* the

195~ at 1316.

'~The court's logic in setting forth the medical necessity defense, by grounding it in the general necessity defense, essentially parallels the D.C. Superior court's reasoning in *~*

¹⁹⁷*state v. Diana*, 604 P. 2d at 1316.

198~ at 1316.

200~ at 1317.

20I~

Washington Court of Appeals concluded that Diana should be given the opportunity to present such a medical necessity defense to the charge of marijuana possession. The court instructed the trial court, on remand, to conclude that the elements of such a defense would be satisfied if the court found that:

(1) the defendant reasonably believed his use of marijuana was necessary to minimize the effects of multiple sclerosis; (2) the benefits derived from its use are greater than the harm sought to be prevented by the controlled substances law; and (3) no drug is as effective in minimizing the effects of the disease.²⁰⁰

The court specified that corroborating medical testimony would be necessary to support the defendant's assertions that marijuana use was necessary for his health.

The court further noted that, on remand, the defendant would bear the burden of proving the existence of medical necessity, an affirmative defense, by a preponderance of the evidence. The opinion instructed the lower court that, if that burden were met, the conviction should be set aside. Finally, the court underscored the narrowly circumscribed nature of the defense which it was setting forth in its Diana opinion. The court emphasized that medical necessity, as a defense to possession, exists only under very limited circumstances not present in the routine case involving controlled substances. On retrial, Diana presented his case with strong corroborating medical evidence, and the

trial court found him not guilty by reason of medical necessity.²⁰²

The ~ opinion remains the controlling decision on the medical necessity defense to marijuana possession charges in Washington state.²⁰³ Although cases invoking the medical necessity defense come to trial relatively infrequently, probably because prosecutors often drop the charges against defendants who are medical users, ~ the Washington Court of Appeals has maintained the position it took in flj~n~. As recently as 1994, the court reaffirmed that position, in Washington v. Cole.²⁰⁵

This case of Washington v. Cole reached the Washington Court of Appeals on the issue of the trial court's granting a prosecutorial motion in limine, to bar Cole from presenting evidence at trial in support of a medical necessity defense to the charge of marijuana possession.²⁰⁶ Cole sought to introduce medical testimony regarding the back spasms that he had suffered regularly since his severe injury in a 1987 logging accident. The state filed a motion in limine to preclude this medical testimony as well as the entire medical necessity defense. At the hearing on the motion, Cole presented an affidavit from an orthopedic surgeon regarding

²⁰²State v. Diana, No. 25230, Doc. 62 (Wash. Superior ct., Spokane cty., March 4, 1981)

~ Washington v. Palmer, 637 P. 2d 239 (1981) at 240 n.l, citing ~ for the existence of the medical necessity defense. ~

~ Washington v. cole, 874 P. 2d 878 (1994) discussed in the text of this essay.

²⁰⁴g~ Arnolds and Garland, ~ note 187.

²⁰⁵State v. cole, 874 P. 2d 878 (1994)

²⁰⁶~ at 880—881.

207~

208~ at 881.

209~ at 882.

his condition. Cole also testified to his own condition, identifying five doctors whom he had seen for his back pain, and noting that records of his treatment existed at the Virginia Mason Pain Clinic. Cole further testified about the pain medications prescribed to him by his doctors, and described the incapacitating side effects of those drugs. He explained that marijuana relieved the muscular tension and nausea that he experienced without those side effects. Cole also testified that he tried to obtain marijuana legally, but that he was unsuccessful. He explained that he chose marijuana out of desperation, because when you're in that much pain, you'll do anything to get rid of the pain.^{2c3}

The trial court questioned the credibility of the medical history and other evidence presented by Cole, and granted the State's motion, subject to reconsideration if Cole presented additional information. Cole submitted additional evidence on two separate occasions, in the form of letters by doctors whom Cole had consulted during his treatment. However, the court found that the evidence remained inadequate, and consequently it would not reconsider its ruling on the State's motion.²⁰⁸ Because he could not present his medical necessity defense, Cole waived his right to a jury trial, and was found guilty as charged.²⁰⁹

Cole appealed, contending that the trial court erred in not giving him the opportunity to present his medical

necessity defense to the jury. The Court of Appeals stated that the function of a motion in limine is the prevention of potentially prejudicial evidence being placed before the jury, until the trial court has ruled upon its admissibility within the full context of the trial itself.²¹⁰ The trial court had accepted the State's contention that Cole had not produced sufficient evidence to support a necessity defense, and that the evidence would serve no purpose but that of prejudicing the trier of fact.

The Court of Appeals noted, however, that a challenge to the sufficiency of evidence requires the trial and appellate courts to interpret the evidence most favorably to the defendant.²¹¹ While the appellate court acknowledged that an issue would be appropriately withdrawn if only a scintilla of evidence were presented in its support, it concluded that such was not the case at hand, as Cole presented some evidence to satisfy each element of the three-pronged test. Thus, the Court of Appeals concluded that Cole should have been allowed to present his medical necessity defense to a jury.²¹² On this basis, the court remanded the case, underscoring the continuing applicability of the medical necessity defense to marijuana possession charges, by stating in conclusion that as noted in *flj~n~*, Cole's interest in preserving his health must be balanced against the State's interest in regulating the drug involved.²¹³

²¹⁰~

²¹¹~ at 882.

²¹²~ at 883.

²¹³~

Although the trial court on remand found that Cole did not present enough evidence to satisfy the necessity defense,²¹⁴ the appellate court's reaffirmation of the ~ opinion nonetheless establishes the continuing applicability of the medical necessity defense to marijuana possession charges in Washington state.

In 1991, the Florida Court of Appeal followed this lead, and also accepted medical necessity as an affirmative defense to possession of marijuana. In Jenks v. Florida,²¹⁵ the Florida Court of Appeal reversed a trial court conviction of Kenneth and Barbara Jenks, a husband and wife who were both suffering from AIDS, who used marijuana to treat the symptoms of their illness.²¹⁶ As a result of the AIDS virus and the side effects of its treatment, both Kenneth and Barbara Jenks were consistently nauseated and rapidly losing weight, causing substantial additional risks to their health. Based on a recommendation which they received in an AIDS support group, the Jenks tried marijuana for the first time, and found that they were able to retain their AIDS medications, eat, gain weight, maintain their health, and stay out of the hospital.²¹⁷ The couple tried to obtain marijuana legally through their physician, but were told that the drug could not be prescribed. Consequently, the Jenks decided to grow two plants, in order to have a ready supply of marijuana and

²¹⁴State v. Cole, No. 90-1-00078-3 (Wash. Superior ct. **Jefferson** cty., April 28, 1995). Defendant Cole was found guilty of possession. j~.

²¹⁵Jenks v. Florida, 582 So. 2d 676 (1991).

²¹⁶Kenneth Jenks was infected with AIDS by a blood transfusion in 1980, and he unknowingly passed it to his wife. ***Id.* at 677.**

²¹⁷~

to avoid the need to buy it on the streets. The Jenks were arrested in March 1990, and readily admitted to police officers that they both had AIDS and used marijuana to relieve their symptoms.²¹⁸

The Jenks waived their rights to jury trial, and agreed that the bench trial should focus on their medical necessity defense.²¹⁹ Because the Jenks' physician was unavailable to testify, the parties stipulated to his testimony. The testimony essentially stated as follows: (1) the physician was unable to find any effective drug for treating the patients' nausea, (2) the nausea was so debilitating that it could cause the defendants' death, (3) he would prescribe marijuana as a drug to control the nausea if he legally could, (4) marijuana is the only drug that controlled the patients' nausea, and (5) he was seeking legal access to marijuana for the Jenks through the FDA IND program.²²⁰ The Jenks also presented testimony by two other expert witnesses on the general subject of the effectiveness of marijuana as medicine.

The trial court rejected the medical necessity defense in general, holding that no such defense existed in Florida.²²¹ Consequently, the court found the Jenks guilty as charged. In a showing of sympathy for the couple's plight, however, the judge placed the Jenks on one year of unsupervised probation. During this interval, the judge ordered the

²¹⁸~

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²²⁰~ at 678.

²²¹Jenks v. State, 15 F.L.W. D1070 (1991)

couple to perform 500 hours of community service, which were to be discharged only by providing care, comfort and concern for each other.²

However, the Jenks nonetheless decided to appeal the conviction, as they did not believe that they should be considered criminals for what they had done. As the Jenks' attorney John Daniel recalls the decision to appeal, he remembers the Jenks' saying, We're going to be gone soon. There's going to be people following in our footprints and in our pain and suffering, and there needs to be some law made one way or the other on it.³ The Florida Court of Appeals accepted the Jenks defense, and stated that the medical necessity defense is merely a more particular application of the necessity defense.⁴ Although the Florida legislature had never explicitly accepted the necessity defense, the court stated that it had been recognized at common law, and... there has been no clearly expressed legislative rejection of such defense.~ The court cited cases dating back to sixteenth-century England supporting the doctrine, and concluded that Florida had effectively adopted the necessity defense pursuant to Section 2.01 of the Florida Statutes, which applied to Florida the general provisions of English common law.² The court held that Florida's statutory

²Jenks v. Florida, 582 So. 2d at 678.

22360 Minutes: Smoking to Live, ~ **note** 157.

²²⁴Jenks v. Florida, 582 So. 2d at 679.

²²⁵Id at 678.

²²⁶Id. citing Florida Statutes § 2.01 (1989), which provides:

The common and statute laws of England which are of a general and not a local nature... are declared to be of force in this state; provided, the said statutes and common law be not inconsistent with the

scheduling of marijuana as a Schedule I substance, the equivalent of marijuana's federal categorization in Schedule I, did not preclude the defense of medical necessity for marijuana use, as the court stated that it is well-established that a statute should not be construed as abrogating the common law unless it speaks unequivocally, and should not be construed to displace the common law more than is necessary. 227

Finally, the court held that the Jenks had sufficiently established the elements of the necessity defense. The court reasoned that the Jenks did not intentionally cause their illness, that they could not achieve the same effectiveness using a drug other than marijuana, and that the evil incurred by their marijuana use was far less than that which would be caused by the life-threatening nausea and weight loss that they would experience without the drug. Consequently, the appellate court held that The trial court erred in rejecting the Jenks' defense and in convicting them.²²⁸ Although given opportunity, the Florida Supreme Court did not overturn this decision²²⁹ and it thereby allowed medical necessity to remain a valid defense to marijuana possession charges in the state.

The Idaho Supreme Court adopted essentially the same position in Idaho v. Hastings.²³⁰ However, the doctrine has not been implemented in Idaho as it was in the Florida because

constitution and laws of the united States and the acts of the Legislature in this state.

²²⁷Jenks v. Florida, 582 So. 2d at 679.

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²²⁹State v. Jenks, 589 So. 2d 292 (1991).

²³⁰State v. Hastings, 801 P. 2d 563 (1990)

the charges against Hastings were dropped following the Idaho Supreme Court's remand for consideration of the necessity defense.²³¹ The case involved a defendant, Lynne Hastings, who used marijuana to control the pain and muscle spasms caused by her affliction with rheumatoid arthritis. She was arrested for possession of marijuana, and she sought to present a defense of medical necessity based on her reasons for using marijuana. The trial judge refused to instruct the jury on such a defense, as he held that medical necessity was not a valid defense in the state of Idaho.²³² However, he did allow defense counsel to create a factual record on the issue, consisting of filed affidavits from experts and potential witnesses, for purposes of future appeal. Hastings then pled guilty, and immediately sought appellate review regarding the medical necessity defense.²³³ The case was then transferred to the Supreme Court of Idaho.

The Idaho Supreme Court stated that it was not inclined to take this opportunity to create a special defense of medical necessity, but that it did believe that defendant's circumstances fell sufficiently within the parameters of the general necessity defense that she was entitled to introduce evidence relating to the common law defense of necessity at the trial.²³⁴ The court referred to the lengthy common law history of the necessity defense, beginning with the English courts' position that a man may break the words of the law,

²³¹State v. Hastings, cR 89-56720 (Idaho **Superior** ct., **Kootenai** cty).

²³²State v. Hastings, 801 P. 2d at 564.

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and yet not break the law itself... where the words of them are broken to avoid greater inconvenience, or through necessity, or by compulsion.²³⁵ The court reasoned that Idaho had accepted this necessity defense, based on the provision of the Idaho Code adopting English common law as follows:

The common law of England, so far as it is not repugnant to, or inconsistent with, the constitution or laws of the United States, in all cases not provided for in these compiled laws, is the rule of decision in all courts of this state.²³⁶

The court also cited recent cases, in Idaho and other states, in which courts recognized necessity as an affirmative defense to such charges as drunk driving, speeding, burglary, assault, escaping from prison, and kidnapping.²³⁷ The court concluded that Lynn Hastings is entitled to present evidence at trial on the common law defense of necessity, and stated that it is for the trier of fact to determine whether she satisfied that defense.²³⁸ However, the case was never retried, because the prosecutor dropped the charges following this Idaho Supreme Court decision.²³⁹ Nonetheless, the Idaho Supreme Court's opinion in *fl~Z.jng.* establishes in that state a common law right for medical marijuana users to mount a necessity defense to charges against them.

Of the states that have had medical marijuana uses brought to trial, a number of states have rejected the

²³⁵*Id.*, citing the English case *Renincer v. Faroossa*, 1 Plowd. 1, 75 Eng. Rep. 1 (1551).

²³⁶*State v. Hastings*, 801 P. 2d at 565, citing Idaho code § 73-116.

²³⁷*State v. Hastings*, 801 P. 2d at 564.

²³⁸*Id.* at 565.

²³⁹*State v. Hastings*, cR 89-56720 (Idaho Superior ct., Kootenai Cty).

possibilities of either recognizing a medical necessity defense or applying the general necessity defense. These state court decisions are reviewed below.

In the New Jersey case of State v. Tate, the state supreme court overturned rulings by the trial and appellate courts that allowed a defendant to present a defense of medical necessity, and the state supreme court held that the defendant would not be permitted such a defense.² The issue arose at the trial court level, following defendant Michael Tate's intention to assert a defense of medical necessity to the charge of unlawful marijuana possession. Tate, a quadriplegic, alleged that he used marijuana because it eased the pain of the spastic contractions to which his body was regularly subject. He further claimed that no other medication gave him equal relief. The State moved for a pretrial resolution that as a matter of law, 'medical necessity' is not a cognizable defense to this criminal charge.²⁴² The trial judge cited the general doctrine of necessity, noting its explicit adoption by New Jersey in the New Jersey Code of Criminal Justice.²⁴³ The judge reviewed the applicability of the doctrine to a variety of circumstances, and finally discussed the emergence from the general necessity doctrine of the medical marijuana necessity defense in U.S. v. Randall and State v. Diana.² The trial court

²⁴² State v. Tate, 505 A. 2d 941 (1986).

²⁴³ State v. Tate, 477 A. 2d 462, 463 (1984).

²⁴⁴ ~

²⁴⁵ ~ at 464, citing New Jersey code of criminal Justice, N.J.S.A. § 2c:

3-2a.

² State v. Tate, 477 A. 2d at 464-467.

thereby concluded that the medical necessity defense applied under New Jersey law as well, and adopted the same criteria for that defense as the ~ court. On this basis, the court denied the State's motion to exclude the medical necessity defense, and ordered the trial to proceed accordingly ²⁴⁵

The State appealed the issue to the state appellate court, and that court affirmed the trial judge's holding substantially for the reasons expressed by the trial court. The appellate court added only that should defendant be acquitted during the impending trial based on a medical necessity defense, his continued use of marijuana will be justifiable only until defendant could either obtain marijuana legally through a research program or until DHHS made synthetic THC available to defendant.² The State once again appealed the issue of excluding the medical necessity defense, seeking review by the Supreme Court of New Jersey⁷

The New Jersey Supreme Court reversed the decisions of the trial and appellate courts, and held that the necessity defense was not available to charges of marijuana possession.²~ The court reasoned that the legislature's codification of common law in the New Jersey Penal Code reflected a legislative intent to create..., a systematic, consistent, comprehensive [state] code to replace the hodgepodge of court-made common law. The court held that this

²⁴⁵State v. Tate, 477 A. 2d at 470.

²⁵State v. Tate, 486 A. 2d 1281 1282-1283 (1984)

²⁴⁷State v. Tate, 505 A. 2d 941 (1986).

248~

change in the basic responsibility for the growth and modernization of the criminal law - - from court to legislature included a shift from court to legislature of the responsibility for defining the scope of former common law defenses, such as necessity³⁹

The court noted that the state's statutory definition of necessity specified that it should not be applied to situations where other code provisions addressing the particular situation exist³ According to the court, the statutory classification of marijuana as a Schedule I controlled substance indicated a legislative intent specifically to prohibit medical use of the substance, except in the context of approved medical research³ Consequently, the court concluded that the legislature had addressed and rejected the possibility of such use as Tate's, and the court thereby held that the defense of 'medical necessity' is clearly precluded by statutory language. The court stated that this court's common law gap-filling authority with regard to the criminal law should be exercised only when there is in fact a gap to be filled, and concluded that because the legislature had effectively addressed the issue, the court need not look to the common law defense of 'necessity' for guidance.²

Nonetheless, the court reviewed the common law, holding that even under the common law standard, unauthorized medical

249[~] at 943.

at 944.

251[~] citing N.J.S.A. § 24:21-5(a).

²⁵²State v. Tate, 505 A. 2d at 945.

use of marijuana could not meet the criteria of necessity. The court stated that the defendant failed to show the absence of an available alternative, due to the continued functioning of the federal supply program and other limited research initiatives. However, the court did not challenge defendant's assertion that the available means are generally unimplemented and ineffective, but instead reasoned that, even if defendant could not de facto receive marijuana through these means, they remained de jure alternatives.³ The court found this sufficient to block medical marijuana use from the necessity defense on common law grounds. In sum, the court concluded that it was precluded from applying common law to Tate's situation since the New Jersey legislature had effectively barred the medical marijuana necessity defense, but that, even if the court were permitted to make a common law evaluation, the circumstances would not fit the parameters of a necessity defense. On this basis, the court reversed the lower courts' holdings, thereby barring Tate and other medical marijuana users in New Jersey from employing a necessity defense to charges of unlawful possession 354

The Massachusetts Supreme Judicial Court reached essentially the same result in its 1991 case Commonwealth v. Kline, although it reached that conclusion through significantly different logic. The defendant in the case, Joseph Hutchins, offered proof that he used marijuana to

253~ at 946.
254~ at 947.

alleviate his suffering from progressive systemic sclerosis (scleroderma), which included hypertension, loss of appetite, nausea, reduced motility, and swollen joints³⁵⁵ The trial judge did not permit him to present a necessity defense to his charges, and he was subsequently convicted³⁵⁶

On appeal, he offered substantial evidence showing that marijuana was the most effective treatment for his symptoms, and the court acknowledged his evidence as such, making no challenges as the Tate court did to whether it met the basic test³⁵⁷ However, the court noted that **It** must be understood... that the oft-repeated principle, that the necessity defense is limited to certain specified circumstances, does not mean that, wherever those circumstances obtain, the defense is automatically available. **258**

The court noted that the determination also depends on whether the harm that would have resulted from compliance with the law significantly outweighs the harm that reasonably could result from the court's acceptance of necessity as an excuse in the circumstances presented by the particular case.³⁵⁹ The court found that the harm to the public of

²⁵⁵commonwealth v. Hutchins, 575 N.E. 2d 741, 742 (1991)

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²⁵⁷The court did not dispute the strength of the evidence in proving the essential elements of necessity: (1) the defendant is faced with a clear and imminent danger, not one which debatable or speculative; (2) the defendant can reasonably expect that his [or her] action will be effective as the direct cause of abating the danger; (3) there is (no) legal alternative which will be effective in abating the danger; (4)

the Legislature has not acted to preclude the defense by a clear and

deliberate choice regarding the conduct at issue..I". at 744.

²⁵⁸~

259I~

allowing the necessity defense would be greater than the harm to the defendant of preventing him from using marijuana. Consequently, the court stated that accepting the defendant's offer of proof, and assuming, as we do without decision, that the circumstances [required for necessity] ... obtain, nevertheless we rule that defendant's proffered evidence does not raise the defense of necessity. The court explained that the alleviation of defendant's medical symptoms... would not clearly and significantly outweigh the potential harm to the public of finding that defendant's conduct was not criminal.²⁶W On this basis, the court affirmed Tate's conviction,²⁶ thereby placing Massachusetts among the states not recognizing necessity as an affirmative defense to medical marijuana use.

The Georgia Court of Appeals has also stated that necessity is not an available defense of charges of marijuana possession. In SDillers v. State, the defendant appealed from a trial court judgment that allowed less than two days between appointment of defense counsel and the case's trial, claiming that this was not sufficient time to prepare the case and that the trial judge erred in not allowing a continuance. The Court of Appeals of Georgia upheld defendants' claim that the trial court had abused its discretion in refusing to grant a continuance, but stated in dicta that the defendant would not be able to present a defense of necessity to his charges, despite the fact that he

260~ at 745.

261~

claimed to use marijuana to alleviate his symptoms of rheumatoid arthritis.

The court stated, It is appropriate to point out that there are no affirmative defenses as to possession or dissemination of marijuana for medical, health and therapeutic purposes.² The court analogized the issue to that of use of pornography, stating that the Legislature had specified certain instances in which what would otherwise be classified as pornography could be used for educational purposes, or for pornotherapy by a psychiatrist. The court reasoned that Marijuana treatment or therapy appears not to have been medically or scientifically recognized within these professions, while on the other hand pornotherapy appears to have been legally and scientifically recognized and sanctioned under certain conditions.³ Thus, the court concluded that the legislature did not intend for marijuana any exceptions from the general law prohibiting the drug, and the court held that it was not within the judiciary's province to challenge that, stating that for us to rule otherwise would be a judicial usurpation of a legislative prerogative.² Consequently, although the court ordered a continuance to defendant for case preparation, the court specified that necessity could not be presented as a defense once the case reached trial³⁵

²⁶²Spillers v. State, 245 S.E. 2d 54, 55 (1978).

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The Minnesota Court of Appeals also rejected the possibility of allowing a medical marijuana user to present a necessity defense. In State v. Hanson, the Court of Appeals held that the trial court had not erred in barring defendant from presenting a medical necessity defense to a charge of marijuana manufacturing. Defendant Hanson suffered from epilepsy, and sought to present evidence at trial that he used marijuana in order to control his symptoms. The trial judge excluded the defense of medical necessity and testimony in support thereof, and Hanson was subsequently convicted.

Reviewing the case, the Court of Appeals upheld the trial court's decision to exclude the medical necessity defense and supporting evidence, and concluded that the legislature had essentially considered and rejected the possibility of allowing an exception for medical use. The court reasoned that, by placing marijuana in Schedule I and by specifying that therapeutic use of marijuana was only permitted in certain approved and controlled research settings, state legislation made clear that the legislature has specifically addressed and determined the possible medical uses of marijuana.~ On this basis, the court held that the trial court did not err in concluding that the medical necessity defense cannot be applied to the possession or use of marijuana,²⁶⁷ thereby placing Minnesota among those states that have held that the defense of necessity is

²⁶⁷State v. Hanson, 468 N.W. 2d 77, 78 (1991)

267~ at 79.

unavailable to individuals who use marijuana for medical purposes.

Finally, Alabama has also joined the ranks of these states barring use of the medical necessity defense for marijuana offenses, through its 1993 Court of Criminal Appeals decision in Kauffman v. State.² The defendant, Scott Kauffman, was a paraplegic suffering from uncontrollable muscle spasms and associated crippling symptoms of an affliction [unspecified] that is progressing from paraplegia to quadriplegia.² The defendant argued that the legally available medications (Tylox and Valium) reached plateaus of effectiveness, at which points marijuana was the only medication that could relieve his suffering.²⁷⁰ He sought to introduce evidence of this at trial, and to present a defense of medical necessity, but the trial judge barred him from doing so. He was subsequently convicted of unlawful possession of marijuana, and appealed to the Court of Criminal Appeals of Alabama, seeking a judgment that the trial judge erred in excluding his medical necessity defense.²⁷¹

Employing much the same logic as the Minnesota court in Hanson, the Alabama appellate court held that it is the opinion of this Court that the Alabama Legislature has precluded the appellant's use of the defense of medical

²Kauffman v. State, 620 So. 2d 90 (1993)

269~

270~ at 91.
271~ at 90—91.

necessity.²⁷² The court reasoned that, by attaching criminal penalties to the manufacture and possession of marijuana, and by providing the opportunity for its use under narrowly circumscribed medical research conditions, the Legislature had considered the issue and implicitly rejected the possibility of allowing unsupervised medical use by those who could not obtain marijuana through the limited means provided by medical research.²⁷³ Thus, the court held that the trial judge acted correctly in excluding the medical necessity defense and supporting evidence, and concluded that the medical necessity defense was not available for marijuana offenses under Alabama law.

As noted at the beginning of this section, many states have not ruled on this issue, because cases where the necessity defense could be appropriate are often dropped at prosecutors' discretion.²⁷⁴ However, as the foregoing discussion illustrates, those states that have considered the issue are divided on whether medical necessity is ever an appropriate defense to marijuana possession charges. In those states that have accepted it, the defense provides a significant validation and protection of medical marijuana use. As the next section of this essay will discuss, state legislative initiatives also provide important means for recognizing and defending the validity of medical marijuana use.

²⁷² ~ at 92.

²⁷³ ~ at 93.

²⁷⁴ ~ Arnolds and Garland, ~ note 187.

State Statutory and Electoral Initiatives

In addition to judicial recourse through the medical necessity defense, state initiatives in the legislative and electoral arenas have supported the medical use of marijuana despite the drug's continuing federal schedule I status. Since 1978, over thirty states have passed resolutions or bills officially recognizing marijuana's medical value. These have ranged from non-binding resolutions encouraging federal sanctioning of medical marijuana use, to bills that both recognize marijuana's medical value and provide for intrastate studies on the drug to be conducted as widely as federal law allows.²⁷⁵

In California, the legislature has taken even larger steps. Bills have passed that would have made medical use of marijuana legal under state law, but Governor Pete Wilson has vetoed these measures. In 1993 such a bill passed both the

²⁷⁵See Alabama S.B. 559 (July 1979); Arizona H.B. 2020 (April 1980); Arkansas Act 8 (April 1981); California S.B. 184 (July 1979); Colorado H.B. 1042 (June 1979); Connecticut H.B. 5090 (July 1981); Florida H.B. 1237 (June 1978); Georgia H.B. 1077 (Feb. 1980); Illinois G.B. 2625 (Sept 1978); Iowa H.F. 512 (June 1979); Louisiana H.B. 1187 (July 1991); Maine H.B. 665 (Aug. 1979); Massachusetts 5. 1582 (Dec. 1991); Michigan 5.B. 185 (Oct. 1979); Minnesota H.F. 2476 (April 1980); Montana H.B. 463

(April 1979); Nevada S.B. 470 (June 1979); New Hampshire S.B. 21 (April 1981); New Jersey A.B. 819 (March 1981); New Mexico H.B. 329 (Feb. 1978); New York S.B. 1123-6 (June 1980); North Carolina H.B. 1065 (June 1979); Ohio S.B. 184 (**March** 1980); Oklahoma S.R. 7 (**March** 1981); Oregon H.B. 2267 (June 1979); Rhode Island H.B. 79.6072 (May 1980); South Carolina 5.B. 350 (Feb. 1980); Tennessee H.B. 314 (April 1981); Texas 5.B. 877 (June 1979); Vermont H.B. 130 (April 1981); Virginia 5.B. 913

(**March 1979**); **Washington H.B.** 259 (March 1979); West Virginia S.B. 366

(March 1979); Wisconsin L.B. 697 (April 1982). ~ ~ Dawn Brazell, Marijuana as Medicine, Post and courier, August 24, 1995, at B1; and Tracie cone, Reefer Madness, San Jose Mercury News, May 14, 1995, at A1 (both stories mentioning that the majority of states have passed nonbinding statutory resolutions favoring medical marijuana availability.)

House and Senate of California, but was vetoed by Governor Wilson on September 30, 1994.²⁷⁶ Another bill, essentially duplicating the first, was introduced in February 1995, passed both houses, and was vetoed by Governor Wilson on October 15, 1995.²⁷⁷ The bills provided that the prohibition against possession, cultivation, or use of marijuana would not apply to an individual who possessed, grew, or processed marijuana for personal medical use or for the medical use of another individual of whom the person is an immediate family member, guardian, or primary caretaker. The bills required that, in order for an individual to qualify for protection under their provisions, he or she must obtain approval in writing from a licensed physician or surgeon, and that approval must specify that the use is specifically for the treatment of AIDS, cancer, glaucoma, or multiple sclerosis.²⁷⁸

According to Governor Wilson's Deputy Press Secretary, Jesus Arredondo, Wilson vetoed the bill based on deference to federal authorities as well as a pragmatic concern with signing state legislation that would leave those Californians who followed it subject to federal prosecution. Said Arredondo, Twice the FDA has looked at marijuana for medical purposes and twice rejected it.... If we were to have allowed these laws, physicians and pharmacists would be subject to federal prosecution for following them. **279**

²⁷⁶california S.B. No. 1364, introduced 1993, passed 1994, vetoed 1994.

²⁷⁷california A.B. No. 1529, introduced 1995, passed 1995, vetoed 1995.

²⁷⁸california A.B. No. 1529, §§ 1 and 2. california S.B. No. 1364, §§ 1 and 2.

²⁷⁹Telephone Interview with Jesus Arredondo, Deputy Press Secretary for Pete Wilson (March 25, 1996)

However, the California legislature has not given up on the possibility of adopting such legislation, as two bills addressing medical marijuana use have been introduced in 1996 and are currently in committee. California Assembly Bill No.

2933 was introduced on February 23, 1996, and has been before

the Assembly Committee on Public Safety since March 7 of this year. That bill contains the same substantive provisions as the two aforementioned bills that Governor Wilson vetoed.²⁸⁰ Governor Wilson's office has affirmed that the Governor's position on the issue has not changed, and has stated that, if this bill passed the legislature, the Governor would most probably veto it as well. Nonetheless, the Governor's representatives admit that the continuing legislative controversy has served the cause of medical marijuana proponents in one respect, as it has heightened public awareness on the issue.²⁸¹

The California legislature is also presently considering another bill on medical marijuana use, which presents a middle ground between the present law under which medical marijuana users are committing felonies, and the system proposed by the above-discussed bills under which medical use would be legal. California Assembly Bill No. 2120, introduced on January 31, 1996, would provide that any individual who grows, processes, or possesses marijuana for personal medical use, under the written approval of a licensed physician or surgeon, would be guilty of a

²⁸⁰California A.B. No. 2933, §§ 1—3.

²⁸¹Telephone Interview with Jesus Arredondo, ~ note 279.

misdeemeanor, rather than a felony.² The bill has been before the Assembly Committee on Public Safety since February 26, 1996, and Governor Wilson's office has no comment on whether the Governor would sign the bill if it were passed.²⁸³

These initiatives by the California legislature have been joined by local and grassroots efforts. The City of West Hollywood, for example, unanimously passed City Council resolution 95-1513 on December 4, 1995, encouraging the legalization of the compassionate use of marijuana for medical purposes.² The resolution asserts that medical use of marijuana has been denied by Governor Pete Wilson and members of the United States Congress for political rather than medical reasons, and it calls upon the State of California not to punish medical marijuana users or their primary caregivers if the marijuana use is undertaken at a physician's recommendation.³⁻⁵

A sentiment similar to that behind this non-binding local resolution has led Californians from across the state to undertake a major grassroots petitioning drive, in an effort to have the issue of medical marijuana use placed on California's November 1996 ballot. The California Constitution enables citizens to bypass the legislature and Governor in enacting legislation by having the electorate

²⁸²california A.B. No. 2120, §§ 1 and 2. Under existing california law, every person who plants, cultivates, harvests, dries, or processes marijuana is guilty of a felony. See california Health and Safety code, § **11358**.

²⁸³Telephone Interview with Jesus Arredondo, ~jj, note 279.

²West Hollywood city council, Res. No. 95-1513, December 4, 1995.

285k

vote directly on a measure. The California State Constitution, Art. II section 8(b), provides that, in order to have a provision placed on the state ballot for such a vote, the proponents of the issue must present to the Secretary of State a petition signed by a specified minimum percentage of the voting population.²⁸⁷

A citizens group, Californians for Compassionate Use (CCU) is leading these efforts to have such an initiative placed on the November 1996 ballot.²⁸⁸ The ballot provision, entitled the Compassionate Use Act of 1996, would amend the California Health and Safety Code by removing prohibitions against possession or cultivation of marijuana by patients with doctors' recommendations or by the patients' primary caretakers for use by the patients.²⁸⁹ CCU is distributing ballots manually by canvassing neighborhoods as well as electronically through the Internet.²⁹⁰

If enough signatures are secured for the measure to obtain ballot access, and if a majority of the electorate then votes in favor of the provision in November 1996, it will become law, and will not be subject to the Governor's approval as the legislative bills have been.²⁹¹ Nonetheless,

²⁸⁶california State constitution, Art. II, Sec. 8(b). **In order to obtain** ballot access, this type of measure must receive the signatures of 13 percent of the voting population. 1~.

²⁸⁷Internet Homepage of californians for compassionate use. ~ Press release of the Marijuana Policy Project, March 20, 1995, retrieved from the Internet.

²⁸⁸Petition for california compassionate use Act of 1996, retrieved from the Internet, Homepage of the cyber-campaign for Medical Marijuana (ccMM), Santa Monica, CA, a subsidiary of californians for compassionate use.

²⁸⁹~

²⁹⁰california State constitution, Article II, Section 8(b).

Governor Wilson's Deputy Press Secretary, Jesus Arredondo,

warns that the law would not be binding, because we [at the state level] cannot supersede federal law, which prohibits such medical use. Arredondo maintains that the electoral ballot provision would be more symbolic than anything else, since medical use would still be subject to federal prosecution.²⁹¹ Clearly, however, this has not dissuaded proponents of the initiative, who continue to lobby for support as the April 19 deadline for collecting the necessary **700,000 signatures approaches.**²⁹²

Although California is the first state to launch a ballot initiative for a provision addressing medical marijuana use specifically, attempts have been made elsewhere to obtain state ballot access for measures which would legalize marijuana generally. California's petitioning drive follows the lead set by a two unsuccessful attempts in Colorado to place a marijuana legalization amendment on the state ballot in 1992 and 1994, in accordance with Colorado State Constitution Art. V section 1(1)-(5.5).²⁹³ These petitioning drives were sponsored by the Colorado Hemp Initiative Project, a group formed in 1992 with the express purpose of seeking state ballot access for the Cannabis and

²⁹¹Telephone Interview with Jesus Arredondo, ~ note 279.

²⁹²Telephone Interview with Nicholas Corbin, Assistant to the Director of Californians for Compassionate Use (March 25, 1996).

²⁹³Colorado State Constitution, Art. V., sec. 1 (1)-(5.5) provides that citizens may gain direct access to the ballot by obtaining on a petition the signatures of a requisite percentage of the electorate. This provision is substantively the same as California's constitutional provision on state ballot initiatives, discussed above.

Hemp Re-Legalization Amendment.²⁹⁴ This amendment, on which the 1992 and 1994 petitioning drives were both based, was much broader than the present California petitioning proposal, as it sought legalization of marijuana for all uses,²⁹⁵ rather than solely for medical purposes as the California initiative proposes. Both the 1992 and 1994 Colorado petitioning drives failed to secure enough signatures for state ballot access, a result which the Colorado Hemp Initiative Project attributes to inadequate funding, poor organization, and a low petition return rate.²⁹⁶ Although not currently undertaking a third ballot initiative, the group plans to do so in the future, and it views the problems confronting it in its past attempts merely as factors which we need to remedy in the future.²⁹⁷

In Oregon, citizens are presently undertaking a petitioning drive to place a measure for broadbased legalization of marijuana on the November 1996 state ballot, in accordance with Article IV section 1(2) (a) of the Oregon State Constitution.²⁹⁸ Like the failed Colorado initiatives, the Oregon measure does not address medical marijuana use

²⁹⁴Hemp Ballot Initiative Update, colorado Hemp Initiative Project, retrieved from the Internet, colorado Hemp Initiative Homepage. ²⁹⁵cannabis and Hemp Re-legalization Amendment, prepared by the colorado Hemp Initiative Project, retrieved from the Internet. **This Amendment would have added to the colorado constitution a section entitled Repeal of Marijuana and Marijuana concentrate Laws, which would have invalidated all state laws restricting cultivation, access, or use of marijuana or hemp.**

²⁹⁶Hemp Ballot Initiative update, ~ **note 294.**

²⁹⁷Id

²⁹⁸Oregon State constitution, Art. IV, sec. 1(2) (a). Like the provisions of the California and Colorado State constitutions discussed above, this **measure in the Oregon State constitution provides that citizens may** obtain direct ballot access for proposed statutory measures by securing **the signatures of a requisite percentage of the state electorate.**

specifically, but rather it seeks to lift prohibitions on marijuana use generally. However, this current Oregon proposal is constructed in an original fashion, as it would establish government regulation of the industry, and would direct profits from that industry towards education (96 percent of profits) and drug abuse treatment (4 percent of profits).²⁹⁹ Indicative of its purpose, the petitioning drive is being led by a group called Pay for Schools by Regulating Cannabis.³⁰⁰

Specifically, this initiative seeks to place on the November 1996 Oregon ballot a measure entitled The Oregon Cannabis Tax Act of 1997. The Act would legalize marijuana, under the regulatory auspices of the Oregon Liquor Control Commission, which would be renamed under the Act as the Oregon Drug Control Commission.³⁰¹ The Commission would have authority over licensing marijuana producers, and would sell cannabis through state liquor stores.³⁰² The same age restrictions that govern alcohol sales would apply to sale of marijuana, blocking minors from access.³⁰³ Profits from licensing and sales would be channeled to education and drug abuse treatment, in the following proportions: 65 percent to state school districts, 30 percent to state institutions of higher education, 4 percent to the department of Human

²⁹⁹Paul Stanford, Pay for Schools by Regulating cannabis, July 21, 1994, retrieved from the Internet, Homepage of Pay for Schools by Regulating cannabis, Portland, OR.

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³⁰¹The Oregon cannabis Tax Act of 1997, §§ 2, 3:474.095.

³⁰²The Oregon cannabis Tax Act of 1997, §§ 3:474.035, 3:474.055. at § 3:474.065.

Resources to fund drug abuse treatment programs, and 1 percent to state school districts to fund a drug education program in the schools.³⁰⁴ The group Pay for Schools by Regulating Cannabis must collect 70,000 signatures in order for this measure to gain access to the ballot, and it has until July 1996 to do so.³⁰⁵

As mentioned previously, neither the Colorado nor the Oregon initiative was designed to address the specific issue of medical marijuana use, as the California electoral initiative was. However, although California's is the only electoral ballot initiative that limits itself to medical marijuana use, California is not the only state undergoing a struggle to reform state laws on that specific issue. As in California, the Massachusetts Legislature recently passed a bill that would shield certified medical marijuana users from punishment, and the Governor has not accepted the bill. Proposed statute H2170, which provided that medical necessity would be a defense to the charges of marijuana possession or use in the state of Massachusetts,~ passed both houses of the legislature in October 1995.³⁰⁷ On November 13, 1995, however, Governor Weld rejected the bill, and returned it the Legislature with a proposed amendment that would allow

at § 3:474.075.

³⁰⁵Paul Stanford, Pay for Schools by Regulating cannabis, ~ note 299.

³⁰⁶As discussed earlier in this essay, the Massachusetts judiciary has not allowed medical marijuana users to employ the common-law necessity defense. This bill proposed to codify that defense, which courts in a few states have accepted as common law, as discussed previously in this essay.

³⁰⁷Relative to the Possession of Marijuana for Medical Purposes, Mass. House No. 2170.

medical marijuana use only by individuals who possessed marijuana pursuant to the State Department of Public Health Therapeutic Research Program.³⁰⁸ This amendment essentially rendered the bill powerless, because there are no marijuana recipients under the state Therapeutic Research Program. It does not appear that there will be any such recipients in the near future, because the federal government is the only legal source of marijuana for the Program, and it has stopped providing a legal supply of medical marijuana, ~ as discussed earlier in this essay.³⁰ Technically, the bill is still alive, with Weld's amendment,³ but proponents of the original bill have asserted that the Governor's action effectively vetoed the bill.³¹²

The bill's sponsor, Representative Jehlen, attempted to reach a compromise with Weld, but such efforts were fruitless. According to Monica Hileman, Legislative Aide to Representative Jehlen, There was some negotiation, but it looks as if we're going to have to override the veto. However, Hileman notes that it's a very touchy subject for some people, and that consequently some politicians may hesitate to support such a measure. In that political

³⁰⁸Relative to the Possession of Marijuana for Medical Purposes, Mass. House No. 5632, citing Mass. Gen. L. ch. 94(c), § **34**.

³⁰⁹Dolores Kong, Pot, a Balm to Some, Faces a New Hurdle, *IbL~n* ~ November 25, 1995, at 13.

³¹⁰See Part III of this essay, section entitled Medical Marijuana Access through the Federal Investigational New Drug Program.

³Mass. House No. 5632 has been forwarded to the committee on House Bills in the Third Reading.

³¹²Michael cutler, Medical Marijuana Legislation Progresses Through the State House, March 3, 1996, retrieved from the Internet, Homepage of The Massachusetts cannabis Reform coalition, Inc., Marblehead, MA.

climate, it remains to be seen whether the bill can garner enough support to override Weld's veto.³¹³

Federal Legislative Initiatives

On November 10, 1995, Representative Barney Frank (DMassachusetts) introduced a bill that would legalize medical marijuana use and would place its production and distribution under federal regulatory authority.³¹⁴ This bill, H.R. 2618, is substantively identical to a bill that was introduced in 1981, 1983, and 1985, by Representative Stewart McKinney (R-Connecticut).³¹⁵ When the bill was originally proposed in 1981, as H.R. 4498, it garnered 74 co-sponsors from both parties,³¹⁶ including Representative Newt Gingrich, who was at that time a second-term Congressman.³¹⁷ Its 1983 reintroduction as H.R. 2282 attracted 66 co-sponsors, some of whom had not co-sponsored the 1981 legislation. In 1985, when reintroduced as H.R. 2232, the bill attained 28 cosponsors. Of the representatives who co-sponsored this legislation at least once in the 1980s, 38 are still in Congress **318**

³¹³Telephone interview with Monica Hileman, Legislative Aide to Mass.

Rep. Jehlen, Boston, MA (March 27, 1996).

³¹⁴H.R. 2618, 104th cong., 1st Sess. (1995).

³¹⁵H.R. 4498, 97th cong., 1st Sess. (1981). H.R. 2282, 98 cong., 1st Sess. (1983). H.R. 2232, 99th cong., 1st Sess. (1985).

³¹⁶H.R. 4498, 97th Cong., 1st Sess. (1981).

³¹⁷Telephone Interview with John **cox**, **Press Assistant for Speaker of the House Newt Gingrich** (March 26, 1996). Gingrich changed his position on the issue, however, before reintroduction of the bill in 1983, and consequently he did not cosponsor the bill in either 1983 or 1985. According to his Press Assistant, John **cox**, **he will not cosponsor the** current bill either.

³¹⁸The following are still members of the u.s. **House of Representatives:** Gary Ackerman (D-NY), Anthony Beilenson (D-CA), Tom Bevill (D-AL), David Bonior (D-MI), George Brown (D-CA), cardiss collins (D-IL), John conyers

The current reintroduction of the bill is entitled A bill to provide for the therapeutic use of marijuana in situations involving life-threatening or sense-threatening illnesses and to provide adequate supplies of marijuana for such use.³¹⁹ The bill would amend the Controlled Substances Act by moving marijuana from Schedule I to Schedule II, and would give the Secretary of Health and Human Services the authority to promulgate regulations for its production and distribution.³²⁰ The bill would also amend the Controlled Substances Act to create in HHS an Office for the Supply of Internationally Controlled Drugs, charged with the responsibility of overseeing the domestic production of marijuana for medical and scientific purposes.³²¹

Under the bill's provisions, the Secretary would take all necessary actions to maintain a domestic supply of marijuana adequate to meet medical and scientific needs, by soliciting bids on contracts for cultivation and delivery of marijuana. Within four months of the end of the marijuana harvest, the Office would be authorized to take physical

CD-MI), Ron Dellums CD-cA), Vic Fazio (D-cA), Horold Ford (D-TN), Barney Frank CD-MA), Sam Gejdenson (D-cT), Sam Gibbons CD-FL), Newt Gingrich (R-GA), Marcy Kaptur CD-OH), Barbara Kennelly (D-cT), John LaFalce CD-

NY), Tom Lantos (D-cA), Sander Levin CD-MI), Bill Mccollum CR-FL), George Miller (D-cA), Norman Mineta (D-cA), James Oberstar CD-MN), John Porter (R-IL), Nick Rahall CD-WV), Charles Rangel CD-NY), Pete Stark CD-cA), Louis Stokes (D-OH), Gerry Studds CD-MA), Edolphus Towns (D-NY),

Bruce Vento (D-MN), Frank Wolf (R-VA), Sidney Yates CD-IL). The following are now Senators: Judd Gregg CR-NH), Tom Harkin CD-IA), James Jeffords CR-VT), Paul Simon CD-IL), Olympia Snowe (R-ME). See also

Marijuana Policy Report, August 1995, retrieved from the Internet, Marijuana Policy Report Homepage. ³¹⁹H.R. 2618, 104th cong., 1st Sess. (1995).

³²⁰~, §§ 2 and 3(a).

³²¹~, § 3(b), adding to Part c of the controlled substances Act § 311(a).

possession of the marijuana harvested. If the Office informed the Secretary that an inadequate supply of marijuana for medical and scientific purposes had been harvested, the Secretary would declare a state of emergency, and would make contractual arrangements for importation of enough marijuana to meet domestic needs.³²²

The bill sets forth procedures for the distribution of medical marijuana, under which physicians would file written applications to the Office seeking permission to prescribe marijuana, and hospitals and pharmacies would obtain supplies from the government to fill prescriptions. The Secretary would be directed to set a price for marijuana that would recoup the costs incurred by the government under this program. The Secretary would also be instructed to promulgate regulations to insure an adequate supply of medically usable marijuana, and to guard against the drug's diversion to illegitimate uses. Pursuant to the latter objective, the bill proposes penalties for using a medicinal marijuana order form for an unauthorized purpose.³ Further, the bill would amend section 505 of the Federal Food, Drug, and Cosmetic Act to provide that the Secretary's approval is not required for introduction or delivery of marijuana into interstate commerce, and to define marijuana as a prescription drug for use only by authorized physicians for specified purposes.³ Finally, the bill would authorize \$5

322~•, § 3(b), adding to Part c of the controlled Substances Act § 312.

323~~, § 3(b), adding to Part c of the controlled Substances Act § 313.

324j~, § 4, amending §§ 505(a) and 503(b) of the Federal Food, Drug, and cosmetic Act.

million for each of the law's first two years in operation for the funding of the Office, and would establish interim provisions ensuring that current recipients of federal marijuana supplies would continue to receive the drug during implementation of the new law.³

So far, the bill has attracted 13 co-sponsors, of which 2 are Republicans and 11 are Democrats.³ The bill has been sent to the Judiciary and Commerce Committees, but no hearings on the bill have yet taken place.³²⁷ Although there is not requisite number of co-sponsors necessary in order for the House to take action on the bill, some proponents believe that it will probably be necessary for a few dozen representatives to first co-sponsor the bill in order for hearings to begin.³

Conclusion:

Although attempts to reschedule marijuana under the provisions set forth in the Controlled Substances Act have failed, proponents of medical marijuana use are actively

~ §§ 5 and 6.

³As of March 26, 1996, the co-sponsors were: Anthony Beilenson CD-CA), Tom Campbell CR-CA), John Conyers CD-MI), Ron Dellums CD-CA), Steve Gunderson CR-Wisconsin), Harry Johnston CD-Florida), Joseph Kennedy (DMA), Zoe Lofgren CD-CA), John Olver CD-MA), Nancy Pelosi CD-CA), Pete Stark CD-CA), Gerry Studds CD-MA), and Lynn Woolsey CD-CA). Telephone interview with Linda Crawford, Secretary to the House Judiciary Committee Minority Staff (March 26, 1996).

327~

³Medical Marijuana Bill Introduced in Congress, Marijuana Policy

~ Nov./Dec. 1995, retrieved from the Internet, Marijuana Policy Project Homepage.

pursuing alternate means of changing the laws on the issue. It is not yet clear whether these reformers will secure their objectives, but the struggle itself reveals important features of our government and society. In essence, by illuminating the myriad means through which the populace can make its voice heard in our nation, the controversy over medical marijuana use demonstrates the successful functioning of our federalist democracy.

As discussed in Part II, advocates of medical marijuana legalization reaped no change from their repeated attempts at reform through the administrative petitioning and judicial review provisions of the Controlled Substances Act. But this statutorily prescribed channel did not represent reformers' only means for effecting change. Robert Randall's legal action against the government, and his consequent receipt of marijuana under the IND Program, demonstrated that people can sometimes attain necessary individual attention from the federal government. However, medical marijuana users' gains under the IND Program were short-lived, thereby proving this approach ineffective at addressing the scope of the issue. Consequently, reformers have sought other alternatives for change.

At the state level, the struggle for reform of medical marijuana laws exhibits the continued functioning of our federalist system as well as its separation of powers. In the judicial branches of some states, significant strides have been made in the common law, through the acceptance of

the medical necessity defense to charges of marijuana possession and use. State legislatures have responded to constituent pressure by passing resolutions recognizing marijuana's medicinal value, and the state legislatures of California and Massachusetts have voted in favor of bills that would shield medical marijuana users from punishment. Some argue that intrastate legalization measures would prove powerless against the continuing federal prohibition, but it is possible that the federal government might defer to the will of such states by not enforcing federal marijuana laws therein if such legislation were passed. Moreover, regardless of their ultimate application, such efforts, like the non-binding state resolutions encouraging federal legalization, demonstrate states' continuing reliance on their localized power under our federalist system. The past and present state electoral ballot initiatives also suggest that reformist activism at a grassroots level remains a viable and powerful means of effecting statutory change.

Finally, the Congressional reintroduction of the medical marijuana bill demonstrates that, even if an issue has been delegated to an agency, it ultimately remains the province of the people through their elected representatives. The reemergence of this question in Congress despite the issue's previous delegation to an administrative agency demonstrates that authority cannot be sequestered from the province of the electorate.

It remains to be seen how the medical marijuana bill will be received in Congress, and how the various state initiatives will play themselves out. Private citizens, courts, and elected officials across the country espouse widely differing opinions on medical marijuana use, in an unresolved debate which has been described as a culture war between the flower-power crowd that believes in natural medicine, and the scientific establishment that believes in white powders.³²⁹ Regardless of its ultimate outcome, however, the continuing struggle for legalization of medical use illuminates the many avenues for reformist activism available in our country and, on a more fundamental level, reveals that the principles of federalism and democracy continue to animate our national polity.

³²⁹Telephone interview with Mark Kleiman, ~ note 156.